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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 leas two nursing personnel to act effectively in t event of fire or other emergency.
8:30-5.1(a)6	6.	Professional and licensed nurse personnel sha be distributed on each tour of duty in order insure that the quality of care required by t patient census is provided.
8:30-5.1(a)7	7.	The amount of nursing time provided for direc patient care shall be limited to nursing duti
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 whc 1. A qualified ADA dietitian, or 2. A graduate dietitian, or 3. A person suited by training and experience foods and nutrition, dietetics, quantity f service, or institutional management for planning and supervision of menus and preparation of meal services. This indivi if requiring further education and prepara should complete the 90-hour course in diet approved by the Department of Health withi 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 bed the hours of care of the Director of Nursing ma 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

8:39

MANUAL OF STANDARDS
FOR
LICENSURE OF LONG-TERM CARE FACILITIES

Second Printing: July 1979

New Jersey State Department of Health
Trenton, New Jersey

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1.0 Definitions and/or Qualifications

1.1 Activities Program shall mean a planned schedule of recreational, social, spiritual, and related activities for patients, designed to stimulate and support the desire to use their physical and mental capabilities to the fullest extent, and to enable them to maintain a sense of usefulness and self-respect.

1.2 Administrator shall mean a person who is licensed by the New Jersey State Department of Health, pursuant to N.J.S.A. 26:2H-27 and 26:2H-28 (Chapter 356, P.L. 1968).

1.3 Ancillary Nursing Personnel shall mean unlicensed workers employed to assist licensed nursing personnel (See 1.34), who complete a training course approved by the Department, and who are certified by the Department, within two years from the approval of these standards.

1.4 Available shall mean ready for immediate use (pertaining to equipment); capable of being reached (pertaining to personnel).

1.5 Business Hours shall mean a time period established by the facility, as defined in its policy manual.

1.6 Bylaws shall mean a set of rules adopted by the facility for governing its operation. (A charter, articles of incorporation, and/or a statement of policies and objectives is an acceptable equivalent.)

1.7 Care Plan (Nursing, Dietary, Rehabilitation, Social Service, Patient Activities) shall mean a written plan documenting an evaluation of the individual patient's needs, short and long term goals, and care and treatment to be provided. Each service that the patient receives shall initiate the development and implementation of its own care plan at the time of the patient's admission, and complete it within seven days. The care plan for each service becomes part of the total patient care plan. The nursing care plan may be incorporated into the patient care plan rather than appearing as a separate document.

1.8 Charge Nurse shall mean a person who is licensed in the State of New Jersey as:

1.8.1 A registered professional nurse; or

1.8.2 A practical (vocational) nurse who is a graduate of a school of practical (vocational) nursing approved by the New Jersey Board of Nursing or the New Jersey Department of Education; and

1.8.3 Has at least one year of full-time, or full-time equivalent, experience in nursing supervision and/or nursing administration in a health care facility; or if a registered professional nurse, has at least three years of full-time, or full-time equivalent, experience in rehabilitative or geriatric nursing.

1.8.4 An unlicensed or foreign nurse with a work letter or permit shall not function as charge nurse.

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

1.10 Clinical Note shall mean a dated, written and signed notation by each member of the health care team who renders a service to the patient, including a description of signs and symptoms, treatment and/or drugs given, the patient's reaction, and any changes in physical or emotional condition. Clinical notes are written into the patient's medical record the day service is rendered.

1.11 Commissioner shall mean the New Jersey State Commissioner of Health.

1.12 Communicable Disease shall mean an illness due to a specific infectious agent or its toxic products, which occurs through transmission of that agent or its products from a reservoir to a susceptible host.

1.13 Conspicuously Posted shall mean placed at a location accessible to and seen by patients and the public.

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

1.15 <u>Controlled Dangerous Drugs</u> shall mean medications subject to the Controlled Dangerous Substances Act of 1970, and to the Controlled Dangerous Substances Act of 1971, New Jersey Administrative Code, Title 8, Chapter 65.

1.16 <u>Current</u> shall mean up-to-date, extending to the present time.

1.17 <u>Dentist</u> shall mean a person who is licensed by the New Jersey State Board of Dentistry, pursuant to N.J.S.A. 45:6 et seq.

1.18 <u>Department</u> shall mean the New Jersey State Department of Health.

1.19 <u>Dietitian or Dietary Consultant</u> shall mean a person who:

1.19.1 Has a bachelor's degree from a college or university accredited by the American Dietetic Association, and who has completed a dietetic internship or dietetic traineeship approved by the American Dietetic Association, or a master's degree plus six months of full-time food service experience in a health care facility; or

1.19.2 Has a bachelor's degree from an accredited college or university with a major in foods or nutrition or the equivalent course work for a major in the subject area, and one year of full-time, or full-time equivalent, experience in nutrition; and

1.19.3 Participants annually in continuing dietary education.

1.20 <u>Director of Nursing Services</u> shall mean a registered professional nurse licensed in the State of New Jersey who has at least two years of full-time, or full-time equivalent, experience in nursing supervision and/or nursing administration in a health care facility; and who has education and/or experience in such areas as rehabilitative or geriatric nursing and participates annually in continuing nursing education.

1.21 <u>Discharge Plan</u> (Medical, Nursing, Dietary, Rehabilitation, Social Service, Patient Activities) shall mean a written plan developed by each service that the patient receives, within seven days following the patient's admission

and which includes the projected level(s) of care needed, the projected timetable for moving the patient to the next level of care, treatment and teaching needed prior to discharge, resources available for post-discharge care, and mechanisms for transfer to other levels of care.

1.22 <u>Discharge Summary</u> (Medical, Nursing, Dietary, Rehabilitation, Social Service, Patient Activities) shall mean a written summary prepared at the time of the patient's discharge by each service that the patient receives, and which includes treatment provided and results, reasons for discharge, preparation of the patient for discharge, and recommendations for the patient's maintenance regimen and continuity of care.

1.23 <u>Disinfection</u> shall mean the killing of infectious agents outside the body, or organisms transmitting such agents, by chemical and physical means, directly applied.

1.23.1 Concurrent disinfection shall mean the application of measures of disinfection as soon as possible after the discharge of infectious material from the body of an infected person, or after the soiling of articles with such infectious discharges, all personal contact with such discharges or articles being minimized prior to such disinfection.

1.23.2 Terminal disinfection shall mean the application of measures of disinfection after the patient has died or been removed to a hospital, or has ceased to be a source of infection, or after the facility's isolation practices have been discontinued. Terminal disinfection is rarely practiced; terminal cleaning generally suffices (see 1.9), along with airing and sunning of rooms, furniture and bedding. Terminal disinfection is necessary only for diseases spread by indirect contact.

1.24 <u>Documented</u> shall mean a signed and dated notation or statement.

1.25 <u>Drug Administration</u> shall mean a procedure in which a prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and regulations governing such procedures. The complete procedure of administration includes removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's

orders, giving the individual dose to the patient, seeing that the patient takes it, and recording the required information, including the method of administration.

1.26 Drug Dispensing shall mean a procedure entailing the interpretation of an order from the original or direct copy of the physician's order for a drug or biological and, pursuant to that order, the proper selection, measuring, labeling, packaging and issuance of the drug or biological to a patient or a service unit of the facility, in conformance with the rules and regulations of the New Jersey State Board of Pharmacy.

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

1.28 Food Service Supervisor (Dietetic Service Supervisor) shall mean a person who:

1.28.1 Is a dietitian; or

1.28.2 Is a graduate of a dietetic technician or dietetic assistant training program approved by the American Dietetic Association; or

1.28.3 Is a graduate of a course, approved by the Department of Education, providing 90 or more hours of classroom instruction in food service supervision, and has one year of full-time, or full-time equivalent, experience as food service supervisor in a health care facility, with consultation from a dietitian; or

1.28.4 Has training and experience in food service supervision and management in a military service equivalent to the programs listed in 1.28.2 or 1.28.3.

1.29 Full Time shall mean a time period of not less than 35 hours, established as a full working week by the facility, as defined in its policy manual.

1.30 Governing Authority shall mean the organization, person or persons designated to assume full legal responsibility for the determination of policy, management, operation and financial viability of the facility.

1.31 Guardian shall mean a person, appointed by a court of competent jurisdiction, who shall have the right to manage the financial affairs and protect the rights of any patient of the facility who has been declared a mental incompetent. In no case shall the guardian of a patient of the facility be affiliated with the facility, its operations or personnel, unless ordered by the court.

1.32 Health Care Facility shall mean a facility so defined in Chapters 136 and 138, Laws of New Jersey, 1971, Health Facilities Planning Act, N.J.S.A. 26:24-1 et seq.

1.33 Job Description shall mean a written list developed for each position in the facility, containing the qualifications, duties and responsibilities, and accountability required of employees in that position.

1.34 Licensed Nursing Personnel (Licensed Nurse) shall mean registered professional nurses or practical (vocational) nurses licensed in the State of New Jersey.

1.35 Licensed Practical Nurse shall mean a person who is licensed by the New Jersey State Board of Nursing, pursuant to N.J.S.A. 45:11-27 et seq.

1.36 Long-Term Care Facility shall mean an institution or a distinct part of an institution which is licensed by the New Jersey State Department of Health to provide health care under medical supervision for 24 or more consecutive hours to two or more patients who are not related to the governing authority or its members by marriage, blood or adoption. A long-term care facility may be either a:

1.36.1 Skilled nursing home, where patients receive at least 2.75 hours of nursing care daily; or

1.36.2 Intermediate care facility, which provides health care and services to individuals who do not require the degree of care and treatment which a hospital or nursing home is designed to provide, but who because of their physical or mental condition require care and services above the level of room and board. In an ICF-Level A facility, patients receive at least 2.5 hours of nursing care daily. In an ICF-Level B facility, patients receive at least 1.25 hours of nursing care daily.

1.37 <u>Medical Care Plan</u> shall mean a written plan initiated and implemented by the physician at the time of the patient's admission, and completed within seven days, and including the level of care needed, special conditions, disabilities or limitations, short and long term goals, assessment of physical capability and mental capacity, and orders for medication, diet, permitted level of physical activity, rehabilitation potential and services, patient activities, special needs for the patient's health or safety, preventive or maintenance measures, and other patient care services. This plan shall be reviewed and revised at least every 30 days for skilled and ICF-A patients and every 60 days for ICF-B patients, or according to an alternative schedule which the physician has justified and documented in the patient's medical record.

1.38 <u>Medical Record Practitioner</u> shall mean a person who:

1.38.1 Is eligible for certification as a registered record administrator (RRA) or an accredited record technician (ART) by the American Medical Record Association; or

1.38.2 Is a graduate of a school of medical record science accredited jointly by the Council on Medical Education of the American Medical Association and the American Medical Record Association.

1.39 <u>Medical Staff</u> shall mean all physicians, dentists, optometrists and podiatrists appointed by the governing authority and responsible to it.

1.40 <u>Monitor</u> shall mean to observe, watch or check.

1.41 <u>Nosocomial Infection</u> shall mean an infection acquired by a patient while in the facility.

1.42 <u>Nursing Care</u> shall mean care given to a patient, as defined by the State of New Jersey Nursing Practice Act.

1.43 <u>Nursing Supervisor</u> shall mean a registered professional nurse who has two years of full-time, or full-time equivalent, experience in nursing supervision and/or nursing administration in a health care facility.

1.44 <u>Nursing Unit</u> shall mean a continuous area, approved by the Department, which includes rooms housing 60 or fewer patients on one floor. Facilities with 60 or fewer patients which have a nursing unit on two floors shall have until June 30, 1980, to comply with this standard.

1.45 <u>Occupational Therapist</u> shall mean a person who:

1.45.1 Is a graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association; or

1.45.2 Is eligible for certification by the American Occupational Therapy Association as an occupational therapist, registered.

1.46 <u>Occupational Therapy Assistant</u> shall mean a person who has completed a training program approved by the American Occupational Therapy Association for occupational therapy assistants, or who is eligible for certification by the American Occupational Therapy Association.

1.47 <u>Optometrist</u> shall mean a person who is licensed by the New Jersey State Board of Optometrists, pursuant to N.J.S.A. 45:1-12 et seq.

1.48 <u>Patient</u> shall mean a person who is under medical care and treatment in the facility. A patient may be classified as:

1.48.1 Ambulant - A person who has the ability to walk on level surfaces and to negotiate stairs and ramps independently of human assistance or supervision, using the following mechanical devices or aids when necessary: prosthesis, brace, cane or handrail;

1.48.2 Nonambulant - A person who is bedfast, chairfast or who can sit in, but not propel, a wheelchair;

1.48.3 Semi-ambulant - A person who:

1.48.3.1 Can walk assisted by crutches only, or on level surfaces independently, but needs human assistance or supervision when negotiating stairs; or

1.48.3.2 Can move from place to place by using a walker or by propelling a wheelchair; or

1.48.3.3 Needs human assistance or supervision for walking on level surfaces.

1.49 Patient Activities Consultant shall mean a person who:

1.49.1 Is a therapeutic recreation specialist, as defined by the National Therapeutic Recreation Society; or

1.49.2 Is an occupational therapist; or

1.49.3 Is a recreation administrator certified by the New Jersey Board of Recreation Examiners and who has at least two years of full-time, or full-time equivalent, experience in a patient activities program in a health care facility.

1.50 Patient Activities Coordinator shall mean a person who:

1.50.1 Has a bachelor's degree from an accredited college with a major in recreation, occupational therapy or a field related to recreation, such as art, music, physical education, group work, or sociology; or

1.50.2 Has an associate degree in recreation and two years of full-time, or full-time equivalent, experience in recreation for the aged, handicapped, or retarded; or

1.50.3 Has a high school diploma or equivalency certificate and two years of full-time, or full-time equivalent, experience, in a social or ecreational program within the last five years, one year of which was full-time in a patient activities program in a health care facility, and has completed at least 36 hours of classroom training, approved by the Department, in activities programming; or

1.50.4 Is certified by the New Jersey Board of Recreation Examiners as a recreation administrator or recreation supervisor, pursuant to Chapter 291, P.L. 1966; or

1.50.5 Is an occupational therapy assistant.

1.51 <u>Patient Care Plan</u> shall mean a written plan coordinated and maintained by the nursing service, with the cooperation of all other services and the participation of the patient and/or the next of kin, sponsor and/or guardian, initiated at the time of the patient's admission, completed within seven days, and included in the medical record at the time of discharge. It contains the physician's orders, goals of care to be provided, a care plan from each of the services that the patient receives, documentation of joint planning of care such as reports of patient care conferences, and documentation of care and services provided. The patient care plan shall be kept current and available to all personnel providing patient care.

1.52 <u>Pharmacist</u> shall mean a person who is registered by the New Jersey State Board of Pharmacy, pursuant to N.J.S.A. 45:14 et seq. , and who has experience and/or training in institutional pharmacy.

1.53 <u>Pharmacist Consultation Sheet</u> shall mean an individual patient record included in the medical record, containing pertinent information regarding the monthly review of the patient's drug regimen by the staff pharmacist or consultant pharmacist, laboratory tests, dietary requirements, physician's and nurse's clinical notes, physician's orders, and progress notes, in order to monitor potential adverse drug reactions, allergies, drug interactions, contraindications, rationality, drug evaluation and laboratory test modifications. The pharmacist shall review and sign the pharmacist consultation sheet, including the drug regimen, at least every 30 days.

1.54 <u>Physical Therapist</u> shall mean a person who is registered by the New Jersey Board of Medical Examiners, pursuant to Chapter 169, P.L. 1963, and who:

1.54.1 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

1.54.2 Prior to January 1966:

1.54.2.1 Was admitted to membership by the American Physical Therapy Association; or

1.54.2.2 Was admitted to registration by the American Registry of Physical Therapists; or

1.54.2.3 Graduated from a physical therapy curriculum in a four-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

1.54.2.4 Had two years of full-time, or full-time equivalent, experience as a physical therapist and has achieved a satisfactory grade through the examination conducted by or under the sponsorship of the United States Public Health Service; or

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

1.54.3 If trained outside the United States:

1.54.3.1 Graduated after 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

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

1.54.3.3 Has acquired one year of full-time, or full-time equivalent, experience under the supervision of an active member of the American Physical Therapy Association; and

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

1.55 . <u>Physician</u> shall mean a person who is licensed or authorized by the Board of Medical Examiners to practice medicine in the State of New Jersey, pursuant to N.J.S.A. 45:9-1 et seq.

1.55.1 Attending physician(s) shall mean the physician(s) responsible for the medical care of a patient in the facility.

1.56 Podiatrist shall mean a person who is licensed by the Board of Medical Examiners to practice podiatry in the State of New Jersey, pursuant to N.J.S.A. 45:5-1 et seq.

1.57 Positive Tuberculin Reactor shall mean a person who has had a positive intradermal tuberculin test, determined on the basis of either a Mantoux test with five tuberculin units of stabilized purified protein derivative, or a vesiculation following a multiple puncture tuberculin test.

1.58 Progress Note shall mean a signed, dated notation by a member of the health care team (excluding ancillary personnel) summarizing information about medical or health care provided and the patient's response to it.

1.59 Reality Orientation shall mean a system to orient the patient to his/her environment in relation to time, place, and person, so that the patient is given the opportunity to become aware of who and where he/she is, and of the time, day, month and year.

1.60 Reasonable Hour shall mean any time between the hours of 8 a.m. and 8 p.m. daily.

1.61 Registered Professional Nurse shall mean a person who is licensed by the New Jersey State Board of Nursing, pursuant to N.J.S.A. 45:11-26 et seq.

1.62 Restorative Nursing shall mean nursing duties concerned with the self-care activities of daily living, including but not limited to positioning, exercise, transfer activities, ambulation, gait training, dressing and undressing, eating, toileting, and personal hygiene and grooming.

1.63 Shift shall mean a time period established as a full working day by the facility, as defined in its policy manual.

1.64 Signature shall mean the name and title of a person written with his/her own hand.

1.65 Single Unit Dose Packaging Drug Distribution System (hereinafter referred to as unit dose system) shall mean a system in which drugs are delivered by a pharmacy to patient areas in single unit packaging, individually wrapped and labeled with the name and strength of medication, lot number and expiration date if available, and ready for administration to patients. The number of doses for each patient shall be sufficient for a maximum of 48 hours.

1.66 Social Work Designee shall mean a person with a bachelor's degree in social sciences, or a high school graduate with four years of full-time, or full-time equivalent, social service experience in a health care facility. One year of experience may be substituted for each year of college.

1.67 Social Worker shall mean a person who has a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education, and at least one year of full-time, or full-time equivalent, social work experience in a health care facility.

1.68 Speech Pathologist or Audiologist shall mean a person who:

1.68.1 Meets the requirements for education and experience for a Certificate of Clinical Competence in the appropriate area (speech pathology or audiology) granted by the American Speech and Hearing Association; or

1.68.2 Meets the educational requirements for certification and is in the process of accumulating the required supervised experience.

1.69 Staff Education Plan shall mean a written plan developed and revised at least annually and implemented throughout the year which describes a coordinated program for staff education for each service, including in-service programs and education, training in patient rights, staff development, on-the-job training, and continuing education, and the intervals and times at which these shall be given. Each employee shall receive education to develop skills and increase knowledge so as to improve patient care. (Occasional attendance at programs or conventions, or speakers invited to the facility, do not solely constitute an acceptable staff education plan.)

1.70 <u>Staff Orientation Plan</u> shall mean a written plan for the orientation of each new employee to the duties and responsibilities of the service to which he/she has been assigned, as well as to the personnel policies of the facility. Each service shall provide an orientation for each new employee, to begin no later than the first day of employment.

1.71 <u>Sterilization</u> shall mean a process of destroying all micro-organisms, including those bearing spores.

1.72 <u>Stop Order</u> shall mean a signed, dated, written statement by a physician mandating the cessation of a written order (except those orders indicated in 6.6.9).

1.73 <u>Supervision</u> shall mean authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his/her sphere of competence, with initial direction and periodic on-site inspection of the actual act of accomplishing the function or activity.

1.73.1 Direct supervision shall mean supervision on the premises within view of the supervisor.

1.74 <u>Unit Record System</u> shall mean a system of filing the medical record as one unit, in one location within the facility.

2.0 **LICENSURE PROCEDURE**

2.1 **Certificate of Need**

2.1.1 According to Chapters 136 and 138, Laws of New Jersey, 1971, Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., a health care facility shall not be instituted, constructed, expanded, or licensed to operate except upon application for and receipt of a Certificate of Need issued by the Commissioner.

2.1.2 Application forms for a Certificate of Need and instructions for completion may be obtained from:

Division of Health Planning and
Resources Development
Review and Comment Unit
New Jersey State Department of Health
P. O. Box 1540
Trenton, NJ 08625

2.2 **Newly Constructed or Expanded Facilities**

2.2.1 The application for license for a new facility shall include written approval of final construction of the physical plant by the Office of Health Care Facilities Construction and Monitoring, Division of Health Planning and Resources Development, Department of Health.

2.2.2 A temporary permit may be issued to a newly constructed facility for the first six months of operation when the following conditions are met:

2.2.2.1 An office conference has taken place between the Licensing, Certification and Standards Program and a representative of the facility's governing authority, the administrator and administrative personnel, consisting of a review of the conditions for licensure and operation;

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

2.2.2.3 Written approvals of the water supply and sewage disposal system by the Environmental Protection Agency and local officials are on file for any water supply or sewage disposal system not connected to an approved municipal system;

2.2.2.4 A final on-site inspection has been made by representatives of the Health Care Facilities Construction and Monitoring Program and the Licensing, Certification and Standards Program, who verify that the building has been constructed in accordance with the final architectural plans approved by the Department; and

2.2.2.5 Professional personnel are employed in compliance with staffing standards established by the Department.

2.2.3 No health care facility shall accept patients until the facility has the approval and/or license issued by the Department. The facility shall accept only that number of patients for which it is approved and/or licensed.

2.2.4 Any health care facility with a construction program, whether a Certificate of Need is required or not, must submit plans to the Department for review and approval prior to the initiation of any work.

2.3 Application for Licensure

2.3.1 Following acquisition of a Certificate of Need, any person, organization or corporation desiring to operate a facility shall make application to the Commissioner of Health for a license on forms prescribed by the Department. Such forms may be obtained by submitting a request to:

Licensing, Certification and Standards
Division of Health Facilities Evaluation
New Jersey State Department of Health
John Fitch Plaza
P.O. Box 1540
Trenton, New Jersey 08625

2.3.2 The Department shall charge a non-refundable fee as follows:

Number of Beds	Fee
1-99	$ 50.00
100-199	100.00
200-299	150.00
300-399	200.00
400-999	250.00

for the filing of an application for licensure of a facility and any annual renewal thereof.

2.3.3 Any individual or individuals considering application for license to operate a facility shall make an appointment for a preliminary conference at the Department with the Licensing, Certification and Standards Program.

2.4 <u>Surveys</u>

2.4.1 When the written application for licensure is approved and the building is said to be ready for occupancy, a survey of the facility by representatives of the Department shall be conducted.

2.4.2 The findings of the survey with respect to adherence to the licensure standards shall be documented and a letter noting any deficiencies found forwarded to the facility.

2.4.3 Following receipt of the letter noting deficiencies, the facility shall notify the Department when the deficiencies have been corrected.

2.4.4 A resurvey of the facility, to be conducted by the Department following correction of the deficiencies, will be scheduled prior to occupancy as needed.

2.4.5 If, on the basis of the Departmental survey, the facility meets the licensure standards, the facility will be issued a temporary permit valid for six months.

2.4.6 Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility and patient records and conferences with patients.

2.5 <u>Full License</u>

2.5.1 A full license shall be issued on expiration of the temporary permit, if periodic surveys by the Department have determined that the health care facility is operated as required by Chapters 136 and 138 and by the rules and regulations pursuant thereto.

2.5.2 A license shall be granted for a period of one year or less as determined by the Department.

2.5.3 The temporary permit or the license shall be conspicuously posted in the facility.

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

2.5.5 The temporary permit or the license, unless sooner suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the licensure date. The facility will receive a request for renewal fee 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the Department.

2.5.6 The temporary permit or the license may not be renewed if local regulations or any other requirements are not met.

2.6 Surrender of License

2.6.1 The facility shall directly notify each patient concerned, the next of kin, and/or sponsor and/or guardian, the patient's physician, and any third party payors concerned at least 30 days prior to the voluntary surrender of a license, or as directed under an order of revocation, refusal to renew, or suspension of license. In such cases, the license shall be returned to the Department within seven working days.

2.7 Waiver

2.7.1 The Commissioner or his/her designee may, in accordance with the general purposes and intent of Chapters 136 and 138 and the standards in this document, waiver sections of the regulations if, in his/her opinion, such waiver would not endanger the life, safety or health of the patient.

2.7.2 A facility seeking a waiver of three standards shall apply in writing to:

Director of Licensing, Certification
and Standards
Division of Health Facilities Evaluation
New Jersey State Department of Health
John Fitch Plaza
P.O. Box 1540
Trenton, NJ 08625

2.7.3 A written application for waiver shall include the following:

2.7.3.1 The nature of the waiver requested;

2.7.3.2 The specific standards for which waiver is requested;

2.7.3.3 Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon full compliance;

2.7.3.4 An alternative proposal which would ensure patient safety;

2.7.3.5 Documentation to support the application for waiver; and

2.7.3.6 If the standards to which waiver is sought contain additional or particular requirements regarding waiver, a discussion of such requirements.

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

2.8 <u>Action against a License</u>

2.8.1 Violations of the following standards shall result in action to impose a fine: 2.1, 2.2.3 and 2.2.4.

2.8.2 A violation of any of the following standards shall result automatically in action leading to the revocation of the license of the facility: 3.2.1, 3.2.2., 3.2.3, 3.2.4, 3.2.5, 3.5, 3.8, 3.16, 3.18.3, 8.1, 9.1, and 10.1.

2.8.3 Violations of the following standards, singly or in combination, shall result in action to revoke the license of the facility: 3.3, 3.6, 3.9, implementation of 3.10, 3.12, 3.18.4, implementation of 6.1, 6.6.12, 8.3, 8.4, 8.9, 8.14, 11.1, 12.1, 13.1, 14.1, 15.1, 16.1, 17.2, implementation of 22.2, 23.1, 23.4.10, 23.5, 23.6, 24.1, 24.7, 26.3 or 26.4, and 26.5.

2.8.4 Violations of the following standards, when occurring in combinations of 15 or more, shall result in action to revoke the license of the facility: 3.13, 3.19, 3.20, implementation of 4.1.8 and 4.1.9, 5.1, 5.3, 6.6.7, 6.6.13, 7.6, 8.6, 8.7, 10.5, 10.7, 10.9, 10.11, 11.4, 11.5, 12.6, 12.7, 13.3, 13.4, 13.7, 14.2, 15.3, 15.4, 15.7, 17.1, 17.5, 17.8, 18.1, 19.1, 20.1, 22.1, 23.3, 23.4, 23.7, 23.8, 24.3, and 25.1.

2.8.5 A combination of violations of 15 or more standards in the areas of nursing, pharmacy, and/or dietary services shall result in action to revoke the license of the facility.

2.8.6 Violations of the standards shall be considered cumulative for a period of three years. Repeated violations of the same standards will be additionally weighted as follows:

2.8.6.1 Double for the second occurrence;

2.8.6.2 Triple for the third occurrence or more.

2.8.7 Violations of the Life Safety Code not corrected within a period of time approved by the Department shall result in action to revoke the license of the facility.

2.8.8 Violations of physical plant standards other than the Life Safety Code, not waivered or corrected within one year, shall result in action to reduce the license to provisional status.

2.8.8.1 Failure to correct violations of physical plant standards within the 90-day time period of the provisional license, or within an alternative time period approved by the Department, shall result in action to revoke the license of the facility.

2.8.9 Violations of 50 standards in any one year, including repeated violations, shall result in action to revoke the license of the facility, when not corrected within 30 days.

2.8.10 If the Department determines that serious operational or safety deficiencies exist, it may require that all new admissions to the facility cease. This may be done simultaneously with, or in lieu of, action to revoke licensure. The Commissioner or the Commissioner's designee shall notify the facility in writing of such determination.

2.8.10.1 The Department may choose to have a facility placed in receivership as an alternative to revocation of licensure.

2.8.11 The Commissioner may order the immediate removal of patients from a long-term care facility whenever he/she determines imminent danger to their health or safety.

2.9 <u>Hearings</u>

2.9.1 The procedures governing all hearings shall be in accordance with the rules and regulations of the Department, as specified in N.J.S.A. 52:14b, N.J.A.C. 8:et seq. and N.J.S.A. 26:2H-1 et seq.

3.0 **General Requirements**

3.1 The facility shall provide nursing care and other health and health-related services, under the supervision of a physician, to patients for 24 or more consecutive hours.

3.2 The facility shall comply with applicable federal, state and local regulations and requirements, including but not limited to:

3.2.1 Building;

3.2.2 Zoning;

3.2.3 Fire;

3.2.4 Safety;

3.2.5 Health; and

3.2.6 Civil rights.

3.3 The facility shall comply with all applicable provisions contained in Chapters 136 and 138, Laws of New Jersey 1971, Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., and amendments thereto.

3.4 The direct and indirect ownership of the facility and the property on which it is located shall be disclosed to the Department. Proof of this ownership shall be available in the facility. Any proposed change in ownership shall be reported to the Department in writing 30 days prior to the change.

3.5 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.

3.6 The facility shall, upon request, submit in writing any plans, manuals and other documents which, as mandated by the standards in this document, require the approval of the Department, to:

Licensing, Certification and Standards
Division of Health Facilities Evaluation
New Jersey State Department of Health
John Fitch Plaza
P.O. Box 1540
Trenton, NJ 08625

3.7 All records, reports and documents required by the standards in this document shall be kept available in the facility at all times and shall be furnished to the Department upon request.

3.7.1 All records and reports required by the standards in this document shall be retained for a period of at least three years after the date of the annual licensure inspection.

3.7.2 All records, reports, documents, policies and manuals specified in these standards shall be made available, upon request, to patients, their next of kin and/or sponsors and/or guardians, and the public, with the written consent of the patient, unless medically contraindicated, after such deletions as are required by law are made. If any of the requested records, reports, documents, policies and manuals contain information involving confidential corporate or business materials, such information may be deleted; however, if information is deleted for such reasons, the requesting party shall be so informed in writing by the administrator of the reasons for deletions. Copies of these documents shall be provided, upon request, at a reasonable charge and within a reasonable time.

3.8 All personnel who require licensure or authorization in order to provide patient care shall be licensed or authorized under the appropriate laws or regulations of the State of New Jersey.

3.9 The facility shall be responsible for providing or arranging services for patients as required by the standards in this document.

3.10 A policy and procedure manual approved by the Department shall be developed and implemented as a guide for organization and operation of the facility. It shall be reviewed annually, and any revisions shall be approved by the Department. The manual shall include:

3.10.1 A written narrative of the program, submitted by the governing authority, describing the services provided, staffing patterns, space requirements, departmental relationships, and other information relating to the fulfillment of its objectives;

3.10.2 Lines of authority, responsibility and accountability, organized and functioning so as to ensure an integrated continuum of services for the patient. An organizational chart shall be provided delineating the lines of authority for the delegation of responsibility down to the patient care level;

3.10.3 A description of the organization, structure and allocation of responsibility and accountability;

3.10.4 A description of and policies regarding the health and medical services provided;

3.10.5 A description of referral mechanisms and linkages with consultants and with other inpatient and ambulatory care facilities in order to provide continuity of patient care;

3.10.6 A description of the system for maintenance of patient records while the facility is in operation, and in the event that it ceases to operate;

3.10.7 A description of the process of evaluation of patient care and staff performance;

3.10.8 Definitions of business hours, full-time, and shift;

3.10.9 A staff orientation and a staff education plan, including plans for each service;

3.10.10 Policies and procedures for the maintenance of personnel records for each employee, including pre-employment information, educational and licensure requirements (if applicable), staff education record, personnel evaluations, and job descriptions; and

3.10.11 A plan for staff pre-employment physical examinations and subsequent health examinations, including content and frequency.

3.11 The manual(s) referred to in 3.10-3.10.11 shall be available in the facility to all staff and to representatives of the Department at all times.

3.12 The facility shall establish and implement procedures for staff approved by the Department, including:

3.12.1 A system of staff pre-employment physical examinations and subsequent health examinations, as stated in the policy and procedure manual;

3.12.2 Staff orientation and education for each service, as specified in the staff orientation and education plans. Each service shall maintain written records of these activities, including the names of persons attending, methods used and an evaluation of their effectiveness;

3.12.2.1 Nurses' aides shall receive education at least six times per year, in accordance with staff orientation and education plans, and shall work under the direct supervision of licensed nursing personnel until the completion of their orientation; and

3.12.3 Written staffing patterns for each service and weekly duty schedules.

3.13 The facility shall have a written agreement for consultant services and for services not provided in the facility. The written agreement shall:

3.13.1 Be dated and signed by a representative of the facility and by the person or agency providing the service;

3.13.2 Include each party's responsibilities, functions, objectives, number of hours and days of the week the provider is in the facility, the financial arrangements and charges, and duration of the written agreement;

3.13.3 Specify that the facility retain administrative responsibility for the services rendered; and

3.13.4 Require compliance with the standards in this document.

3.14 Each consultant shall provide written documentation of each visit made to the facility, to include, but not be limited to, services rendered, problems noted and recommendations made.

3.15 The facility shall develop in writing and implement a method of patient transportation for health care outside the facility which provides for security and accountability for the patient and his/her personal effects.

3.16 The facility shall have in effect a transfer agreement with one or more hospitals such that inpatient hospital care or other hospital services are available to the facility's patients. The transfer agreement shall:

3.16.1 Ensure the transfer of patients between the hospital and the facility whenever such transfer is ordered by a physician; and

3.16.2 Specify the type of patient records to be transferred with the patient, and the method and timetable for the transfer of such records.

3.17 The facility shall notify the Department immediately by phone, followed within 72 hours by a written confirmation, of the following:

3.17.1 Expected or actual interruption or cessation of operations and/or services listed in the standards in this document, or of such other services as fuel, water, heat, gas or electricity;

3.17.2 Termination of employment of the administrator and/or the director of nursing services, and the name and qualifications of his/her replacement. If a new licensed administrator cannot be designated within 48 hours, the Department shall be so notified in writing and the facility shall make arrangements for licensed administrative supervision on a consultant basis. A new licensed administrator shall be appointed within 30 days;

3.17.3 Occurrence of epidemic disease in the facility; and

3.17.4 All fires, disasters and all deaths resulting from accidents or incidents in the facility. The written confirmation shall contain information about injuries to patients and/or personnel, disruption of services and extent of damages.

3.18 The facility shall maintain on file written documentation of:

3.18.1 Annual inspection of the facility by the local fire authority;

3.18.2 Semi-annual inspection of the fire detection system by the installing company or a company approved by the Department;

3.18.3 Annual inspection of the elevator(s) by the local authority responsible for such inspection. If no local authority is responsible, the installing company or a company approved by the Department shall perform the inspection; and

3.18.4 Annual inspection of boiler and generator systems by a boilermaker or mechanic not on the staff of the facility.

3.19 The facility shall conspicuously post a notice that the following information is available in the facility, during business hours, to patients, their next of kin and/or sponsors and/or guardians, and the public:

3.19.1 All waivers granted by the Department;

3.19.2 The name and address of any person, partnership or corporation having an ownership interest in the facility;

3.19.3 Any proposed change in ownership;

3.19.4 All records, reports, documents, policies and procedures, and manuals required by the standards in this document;

3.19.5 A list of deficiencies from the last annual licensure inspection and certification survey report (if applicable);

3.19.6 A list of the facility's committees, including but not limited to the Patient Care Policy, Evaluation, Pharmaceutical, Discharge Planning and Infection Control Committees, and the membership, minutes, and annual reports of each;

3.19.7 The names and addresses of members of the governing authority;

3.19.8 Any changes of membership of the governing authority, within 30 days of the change;

3.19.9	Policies and procedures regarding patient rights, obligations and prohibitions, as set forth in N.J.S.A. 30:13-1 et seq; and
3.19.10	Visiting hours and business hours, including the policies of the facility regarding limitations and activities during these times.
3.20	Copies of the documents listed in 3.19-3.19.10 shall be provided upon request within a reasonable time, and at a reasonable charge payable in advance.

4.0 **Governing Authority**

4.1 The facility shall have a governing authority which shall assume full legal responsibility for the determination and implementation of policy and for management, operation and financial viability of the facility. The governing authority shall be responsible for, but not limited to, the following:

4.1.1 Services provided in the facility and the quality of care rendered to patients;

4.1.2 Provision of a safe physical plant equipped and staffed to maintain the facility and services;

4.1.3 Adoption and documented annual review of written bylaws and the budget;

4.1.4 Written confirmation of appointments made by the governing authority;

4.1.5 Formulation and documented annual review of personnel policies;

4.1.6 Review and documented approval of patient rights and patient care policies developed by the Patient Care Policy Committee;

4.1.7 Determination of the frequency of meetings of the governing authority, holding such meetings, and documenting them through minutes, including a record of attendance;

4.1.8 Establishment and implementation of a system whereby patient and staff grievances and/or recommendations, including those relating to patient rights, can be identified within the facility. This system shall include a feedback mechanism through management to the governing authority, indicating that action was taken; and

4.1.9 Establishment of staff committees including, but not limited to, Patient Care Policy, Evaluation, Pharmaceutical, Discharge Planning, and Infection Control Committees.

5.0 Administration

5.1 The governing authority shall appoint a licensed administrator, pursuant to N.J.S.A. 26:2H—27 and 26:2H-28 (Chapter 356, P.L. 1968).

5.2 The administrator or his/her designee shall be accountable to the governing authority.

5.3 An alternate shall be designated in writing to act in the absence of the administrator.

5.4 In a facility with more than 240 patients, a second full-time administrator shall be appointed. An administrative supervisor, who need not be a licensed administrator, shall be appointed and assigned to the evening shift, and shall be directly responsible to the administrator. Computation of direct care time shall not include the hours of the administrative supervisor.

5.5 In a facility where a licensed administrator has both administrative and other functions, such as nursing responsibilities, the facility shall maintain written time schedules which specify the hours spent by the individual in each function.

5.6 The administrator shall be responsible for, but not limited to, the following:

5.6.1 Planning for and administration of the management, operational, fiscal and reporting components of the facility;

5.6.2 Ensuring the development of, implementing and enforcing all policies and procedures, including patient rights;

5.6.3 Employing and placing all staff within the facility;

5.6.4 Ensuring the provision of staff education and orientation;

5.6.5 Ensuring that a file is maintained for each staff member, including his/her name, qualifications, current license number (if applicable), personnel evaluation, and records of physical examination and staff education;

5.6.6 Participating in policy and administrative decision-making;

5.6.7 Administering and supervising the non-clinical operations of the program;

5.6.8 Acting as a liaison to the governing authority on behalf of the medical director, the staff and the patients;

5.6.9 Within 30 days of a patient's discharge, ensuring that the patient care plan, including the discharge summary and the discharge plan, are provided in the medical record; and

5.6.10 Together with the medical director, developing and implementing procedures for:

5.6.10.1 Maintaining administrative relationships, communication and integration with support services and community resources; and

5.6.10.2 Communicating with staff through group meetings, individual conferences, written memoranda and/or other methods of exchanging information.

6.0 **Patient Care Policies**

6.1 The facility shall establish and implement written patient care policies, approved by the Department, governing the medical, nursing and other services provided.

6.2 The facility shall establish a Patient Care Policy Committee, consisting of, but not limited to, the medical director or one or more members of the medical staff, one or more registered nurses, and a representative of each service offered by the facility.

6.3 The Committee and the governing authority shall review annually all patient care policies developed by the Committee, as well as all policies developed and implemented by each service, and shall document the review.

6.4 All patient care policies shall be available to physicians, staff, patients and their next of kin and/or sponsors and/or guardians, and the public.

6.5 The administrator shall be responsible for ensuring the development, implementation and enforcement of all patient care policies.

6.6 The facility shall have in effect written policies developed by the Patient Care Policy Committee, which shall include, but not be limited to, the following:

6.6.1 Patient rights;

6.6.2 Care of patients, to ensure that all patients are kept clean, dry and comfortable;

6.6.3 Reality orientation for patients, integrated into patient care services;

6.6.4 Levels of care provided;

6.6.5 A difinition of emergency;

6.6.6 Emergency care of patients, care of patients during an episode of communicable disease, care of patients with tuberculosis whose disease is not communicable following initiation of chemotherapy or whose disease is non-pulmonary and therefore not transmissible, and care of critically ill or mentally disturbed patients;

6.6.7 Care of deceased patients, to include, but not be limited to, the following:

6.6.7.1 Pronouncement of death by a physician. The next of kin and/or sponsor and/or guardian shall be notified at the time of death. The deceased shall not be discharged from the facility until pronounced dead and the death documented in the patient's medical record;

6.6.7.2 Removal of the deceased from rooms occupied by other patients; and

6.6.7.3 Transportation of the deceased in the facility, and removal from the facility, in a dignified manner;

6.6.8 Verbal and telephone orders, to ensure that they are accepted only by personnel authorized under the laws or regulations of the State of New Jersey, written into the patient's medical record by the person accepting them, and countersigned by the physician within 48 hours;

6.6.9 Stop orders for medical and laboratory services, indicating length of time orders may be in effect;

6.6.10 Medical record-keeping;

6.6.11 Provision for podiatric services, dental services, eye examinations, eye glasses, auditory testing and hearing aids;

6.6.12 Admission of patients, so that the facility:

6.6.12.1 Admits a patient only on physician's orders which indicate level of care needed;

6.6.12.2 Requires that each patient admitted be under the supervision of a physician;

6.6.12.3 Ensure that, prior to or at the time of the patient's admission, the administrator or his/her designee, and/or the director of nursing services, conducts a personal interview with the patient (if mentally competent) and the next of kin and/or sponsor and/or guardian (if available). A summary of all interviews shall be recorded in the patient's medical record; and

6.6.12.4 Ensures that, prior to or at the time of the patient's admission, the patient (if mentally competent), next of kin and/or sponsor and/or guardian signs a written admission agreement which shall include the following provisions:

6.6.12.4.1 The patient, next of kin and/or sponsor and/or guardian agrees to a visit by a physician at least once every 30 days for skilled and ICF-A patients, and every 60 days for ICF-B patients, or the number of days in an alternative schedule of patient visits which the physician has justified and documented in the medical record; and

6.6.12.4.2 The patient, next of kin and/or sponsor and/or guardian agrees that if or when the patient's attending physician is not available, the administrator shall be authorized to arrange for another physician to visit the patient;

6.6.13 Restrictions to the admission and retention of patients, to ensure that:

6.6.13.1 Patients under 16 years of age are admitted only to an area within the facility approved for such occupancy by the Department;

6.6.13.2 If the facility is not of fire-resistive construction, blind, nonambulant and semi-ambulant patients are housed on the first floor;

6.6.13.3 A patient who manifests such a degree of behavioral disorder that he/she is a danger to himself/herself or others, or whose behavior interferes with the health or safety of other patients, is not admitted or retained;

6.6.13.4 A patient diagnosed as having narcotic or alcohol addiction, or habituation to depressant or stimulant drugs, is not admitted to or retained in the facility, unless the patient suffers from other illnesses; and

6.6.13.5 Any applicant who, after applying in writing, is denied admission to the facility for reasons other than lack of space, and/or the next of kin and/or sponsor and/or guardian, is given the reason for such denial in writing, signed by the administrator, within 15 days;

6.6.14 Financial arrangements, to ensure that the facility:

6.6.14.1 Maintains a written record of all financial arrangements with the patient, next of kin and/or sponsor and/or guardian, with copies furnished to each party; and

6.6.14.2 Assesses no additional charges, expenses or other financial liabilities in excess of the daily, weekly or monthly basic rate included in the admission agreement, except:

6.6.14.2.1 Upon written approval and authority of the patient, next of kin and/or sponsor and/or guardian. Copies of the written approval shall be given to the patient and/or next of kin and/or sponsor and/or guardian, and shall be attached to the quarterly financial statement; or

6.6.14.2.2 Upon written orders of the patient's attending or alternate physician, stipulating specific services and supplies not included in the admission agreement; or

6.6.14.2.3 Upon 30 days' prior written notice to the patient, next of kin and/or sponsor and/or guardian of additional charges, expenses or other financial liabilities due to the increased cost of maintenance and/or operation of the facility; or

6.6.14.2.4 In the event of a health emergency involving the patient and requiring immediate, special services or supplies to be furnished during the period of the emergency;

6.6.15 The use of restraints, to ensure that the facility establishes procedures for the use of restraints to prevent injury to the patient and/or others. Policies governing restraints shall, as a minimum:

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;

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6.6.15.2 Prohibit the use of locked restraints and confinement of a patient in a locked or barricaded room;

6.6.15.3 Require that a physical restraint be used only when authorized in writing by a physician for a specified period of time except when necessitated by an emergency, in which case it shall be approved by the medical director, or the director of nursing services or his/her designee, and shall be applied by a licensed nurse who shall document in the patient's medical record the circumstances requiring the use of such emergency physical restraint;

6.6.15.4 Specify that orders for restraints not be in force for longer than 12 consecutive hours, unless authorized for a specified period of time and so documented in the patient's medical record;

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

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6.6.15.6 Specify that physical restraints be used so as not to cause physical injury or discomfort to the patient. Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two-hour period in which the restraint is employed, to ensure opportunity for elimination of body wastes, good body alignment, circulation, and change of position;

6.6.16 Rules for smoking, to ensure that:

6.6.16.1 Smoking is prohibited in any room, area or compartment where oxygen, inflammable liquids or combustible gases are used or stored, and in any other hazardous location. Such areas shall be posted with NO SMOKING signs;

6.6.16.2 Smoking areas are designated by posted signs, and rules governing smoking in such areas are promulgated and enforced;

6.6.16.3 Smoking in patient rooms is not permitted; and

6.6.16.4 At least 25 percent of the dining room is designated as a non-smoking section;

6.6.17 Procedures for interpretation, if the patient population is non-English speaking, or for patients who are blind or deaf.

7.0 Medical Services

7.1 The governing authority shall appoint a physician to serve as medical director who shall be responsible for the direction, provision and quality of medical care provided.

7.2 The medical director shall be directly or indirectly accountable to the administrator.

7.3 The medical director shall be responsible for, but not limited to, the following:

7.3.1 Delineating the responsibilities of attending physicians;

7.3.2 Communicating with attending physicians to ensure that medical care plans are written upon the patient's admission and are kept current;

7.3.3 Establishing written policies for utilization of medical consultant and specialist services;

7.3.4 Monitoring the health status of the facility's personnel;

7.3.5 Providing documented investigation of incidents and accidents that occur on the premises, in order to identify and correct hazards to health and safety;

7.3.6 Providing documented information to the administrator, in order to ensure a safe and sanitary environment for patients and personnel;

7.3.7 With the administrator, assuming responsibility for the execution of patient care policies;

7.3.8 Participating in the development and direction of ongoing staff educational programs;

7.3.9 Developing and maintaining a system of medical audit and evaluation of patient care; and

7.3.10 Participating or ensuring physician representation in staff committees, including, but not limited to, the Patient Care Policy, Evaluation, Pharmaceutical, Discharge Planning and Infection Control Committees.

7.4 In addition to those items listed in 7.3-7.3.10, the medical director in a facility with a medical staff shall be responsible for planning, developing and implementing written medical policies, including medical staff bylaws, rules and regulations, in cooperation with the medical staff. These shall be submitted to the governing authority for approval, and shall include, but not be limited to, the following:

7.4.1 A table of organization for the medical staff;

7.4.2 A plan for medical staff meetings and documentation through minutes; and

7.4.3 The qualifications, status and privileges of physicians, dentists, optometrists, podiatrists and others who may be granted staff membership.

7.5 The facility shall:

7.5.1 Require that, upon admission, the patient, next of kin and/or sponsor and/or guardian designate in writing an attending physician for the patient;

7.5.2 Obtain from the attending physician confirmation that he/she will visit the patient and revise the medical care plan not less than once every 30 days for skilled and ICF-A patients, and every 60 days for ICF-B patients, or in accordance with an alternative schedule which he/she justifies and documents in the patient's medical record; and

7.5.3 Require that the attending physician, the patient, next of kin and/or sponsor and/or guardian designate an alternate physician to attend the patient for periodic or emergency visits whenever the attending physician is not available.

7.6 The administrator or his/her designee shall:

7.6.1 Verify that the patient's medical record contains documentation of the name, address and telephone number of the attending physician;

7.6.2 Notify the attending physician whenever a physician visit is required or in an emergency;

7.6.3 Ensure that the patient is visited by a physician for required visits and in response to an emergency;

7.6.4 Assist in the development of, and implement, written procedures to provide emergency medical care. The written procedures and a list of physicians available to provide emergency medical care shall be posted at each nurses' station; and

7.6.5 Ensure that the patient's next of kin and/or sponsor and/or guardian is notified no more than three hours after the occurrence of an accident or of deterioration in the patient's condition, and that the notification is documented.

7.7 The patient's attending physician shall agree:

7.7.1 To visit the patient not less than once every 30 days for skilled and ICF-A patients, and every 60 days for ICF-B patients, and to write, sign and date a progress note at the time of each visit. An alternative schedule for visits may be adopted if the physician determines, and so justifies in the patient's medical record, that the patient's condition does not necessitate visits as often as every 30 days (or 60 days for ICF-B patients);

7.7.2 To review the medical care plan and to revise it as necessary, at least every 30 days for skilled and ICF-A patients, and every 60 days for ICF-B patients, or in accordance with an alternative schedule which he/she justifies and documents in the patient's medical record; and

7.7.3 To be called in any emergency.

7.8 The attending physician shall prescribe a written medical care plan upon admission. This plan shall be reviewed with a licensed nurse and revised as necessary at least every 30 days for skilled and ICF-A patients, and every 60 days for ICF-B patients, or in accordance with an alternative schedule which the physician justifies and documents in the patient's medical record.

7.9 The attending physician shall enter in the patient's medical record:

7.9.1 A signed, dated admission and medical history, and a report of physical examination, including results of chest x-ray (at the discretion of the physician), medical findings, diagnoses and rehabilitation potential. Patients under age 35 shall also have an intradermal tuberculin test (and follow-up if necessary), with the exception of positive tuberculin reactors, who shall have a chest x-ray given within a period of time specified and documented by a physician in the patient's medical record. These shall be provided by the attending physician within 48 hours before or after the patient's admission to the facility, unless such history and examination were performed within five days prior to admission and documented in the patient's medical record;

7.9.2 A medical care plan;

7.9.3 All initial and subsequent orders for services to be provided to the patient, including frequency and modality of rehabilitation therapy; and

7.9.4 The medical portion of the discharge summary and discharge plan.

8.0 Nursing Services

8.1 The facility shall provide nursing services 24 hours a day, seven days a week.

8.2 The facility shall maintain the organization, management and operation of nursing services in accordance with a written organizational plan which shall describe the responsibility, authority and accountability relationships of personnel, the functional structure of the service, and the relationship of the nursing service to other services.

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.*

8.4 There shall be nursing and ancillary personnel on each nursing unit to provide at least 2.75 hours of direct nursing care for each skilled patient, 2.5 hours for each ICF-A patient, and 1.25 hours for each ICF-B patient, during a 24-hour period.

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.

8.6 No member of the nursing staff shall be counted in the staffing pattern of more than one nursing unit per shift. Facilities with 60 or fewer patients which have a nursing unit on two floors shall have until June 30, 1980, to comply with this standard.

8.7 A licensed practical nurse shall function under the direction of a registered professional nurse or a licensed or otherwise legally authorized physician or dentist.

*In facilities with 30 or fewer patients, a licensed nurse may be assigned to the night shift through June 30, 1980. After June 30, 1980, all facilities shall comply with standard 8.3.

8.8 The facility shall ensure that the duties and responsibilities of levels and types of nursing personnel are described in the job descriptions and in the policy and procedure manual of the nursing service, and that personnel are assigned duties based upon their education and training.

8.9 Nursing and ancillary personnel for each nursing unit shall ensure that each patient:

8.9.1 Has a written patient care plan, coordinated and maintained by the nursing service in accordance with the physician's medical care plan, and implemented upon admission;

8.9.2 Is kept clean, dry and comfortable;

8.9.3 Receives treatments, medications, restorative care and diets, as ordered by the physician;

8.9.4 Receives care toward prevention of decubitus ulcers; and

8.9.5 Receives care toward prevention of infection, accident and injury.

8.10 The facility shall have on duty at all times during the day shift a registered professional nurse designated in writing as the director of nursing services. A registered professional nurse shall be designated in writing to act in the director's absence on evening or night shifts or when the director is not available.

8.11 The director of nursing services shall be responsible for the direction, provision and quality of nursing care provided. He/she shall be responsible for, but not limited to, the following:

8.11.1 Developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the nursing service;

8.11.2 Participating in total planning and budgeting for the nursing service, including recommending to the administrator the number and levels of nursing and ancillary personnel to be employed;

8.11.3 Coordinating and integrating the nursing service with other patient care services;

8.11.4 Participating in staff committees, including, but not limited to, the Patient Care Policy, Evaluation, Pharmaceutical, Discharge Planning and Infection Control Committees;

8.11.5 Maintaining working relationships with administration through conferences, written memoranda and other methods of exchanging information;

8.11.6 Developing and maintaining written job descriptions for nursing and ancillary personnel;

8.11.7 Selecting for employment, designing staffing patterns for, and assigning duties to all nursing and ancillary personnel, to provide 24-hour-a-day coverage;

8.11.8 Ensuring supervision and evaluation of nursing and ancillary personnel;

8.11.9 Assisting in the development of, and participating in, staff orientation and educational programs for the facility and the nursing service, and documenting these activities;

8.11.10 Ensuring that a registered professional nurse prepares an individual nursing care plan for each patient upon admission, reassesses the nursing needs of each patient every 7 days for skilled patients, every 14 days for ICF-A patients, and every 30 days for ICF-B patients, writes clinical notes, and writes progress notes indicating the patient's response to nursing care at least every 30 days for skilled and ICF-A patients, and every 60 days for ICF-B patients, or in accordance with an alternative schedule which he/she justifies and documents in the patient's medical record;

8.11.11 At the time of discharge, ensuring that the nursing portion of the patient care plan, the nursing care plan, and the nursing portion of the discharge summary and discharge plan are provided in the patient's medical record; and

8.11.12 Providing a daily summary, including, but not limited to, the daily census and staffing patterns, and indicating classification and number of nursing, ancillary and relief personnel who worked on each nursing unit for each shift.

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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:

8.12.1 Assisting in employment interviews and in hiring and assigning nursing and ancillary personnel to nursing units;

8.12.2 Making daily rounds to observe patients and nursing care;

8.12.3 Reviewing and evaluating patient care plans and nursing care plans;

8.12.4 Supervising and evaluating staff performance;

8.12.5 Making rounds with charge nurses and physicians to visit patients;

8.12.6 Consulting with the charge nurse to determine the nursing care needed and to make staffing recommendations to the director of nursing services;

8.12.7 Assisting the director of nursing services in determining staff educational needs and in the planning and organization of staff orientation and educational programs; and

8.12.8 Assisting the director of nursing services in developing and maintaining written objectives, standards of practice, policies, a procedure manual and an organizational plan for the nursing service.

8.13 The director of nursing services shall designate in writing a charge nurse on each nursing unit for each shift, seven days a week. The charge nurse shall be responsible for, but not limited to, the following:

8.13.1 Supervising and evaluating all nursing and ancillary personnel and activities related to nursing care in the nursing unit;

8.13.2 Assessing the needs of each patient, and developing and implementing the nursing portion of the patient care plan and the nursing care plan for meeting those needs;

8.13.3 Assigning duties and delegating responsibility to nursing and ancillary personnel for provision of nursing care;

8.13.4 Assisting in the organization and teaching of staff orientation and educational programs for nursing and ancillary personnel;

8.13.5 Assisting the director of nursing services in developing and maintaining written objectives, standards of practice, policies, a procedure manual and an organizational plan for the nursing service;

8.13.6 Assuming responsibility for direct patient care; and

8.13.7 Assuming responsibility for observations, evaluations and reporting of patients' symptoms, reactions and progress to the attending physician.

8.14 In accordance with written job descriptions, nursing and ancillary personnel shall be responsible for, but not limited to, the following:

8.14.1 Providing direct nursing care;

8.14.2 Administering medications and/or treatments to patients upon written order of a physician, in accordance with the State of New Jersey Nursing Practice Act and the standards set forth in Sections 7.0 and 9.0. Only the following nursing personnel shall be permitted to administer medications:

8.14.2.1 Registered professional nurses;

8.14.2.2 Licensed practical nurses who have undergone formal training in the administration of medications, in programs approved by the New Jersey State Board of Nursing;

8.14.2.3 Nurses with valid "permission to work" letters issued by the New Jersey State Board of Nursing (N.J.A.C. 13:37-3.5; 13:37-4.6; 13:37-10-4; and 13:37-11.5). This excludes foreign exchange visitor nurses;

8.14.2.4 Unlicensed nurses who are graduates of domestically accredited nursing schools, pending the results of the first two consecutive licensing examinations immediately following the completion of their nursing program (N.J.A.C. 13:37-2.7 and 13:37-9.5); and

8.14.2.5 Student nurses in a school of nursing approved by the New Jersey State Board of Nursing, under the direct supervision and within immediate view of a registered professional nurse;

8.14.3 Assessing the needs of each patient and developing, reviewing, revising and implementing the nursing portion of the patient care plan and the nursing care plan for meeting those needs;

8.14.4 Assisting patients who need help with meals. Nursing and/or ancillary personnel shall be in the dining room during each meal;

8.14.5 Assessing, observing and monitoring the patient's response to treatment and nursing care;

8.14.6 Coordinating nursing care with other patient care services;

8.14.7 Teaching, supervising and consulting with other personnel, the patient and family members regarding methods of meeting the nursing care needs and other related problems of the patient. (Licensed nursing personnel only shall perform these functions); and

8.14.8 Providing restorative nursing to all patients. This shall include, but not be limited to, the following:

8.14.8.1 Maintaining the patient's body positioning and alignment both in and out of bed, performing passive range of motion exercises, and teaching the patient to perform active range of motion exercises;

8.14.8.2 Encouraging and assisting bedfast patients to change position at least every two hours day and night to stimulate circulation and prevent decubitus ulcers, contractures and other deformities;

8.14.8.3 Encouraging patients to remain out of bed, except when contraindicated by a physician's orders;

8.14.8.4 Encouraging patients to achieve independence in activities of daily living by teaching self-care, transfer and ambulation activities;

8.14.8.5 Assisting patients to use their prosthetic devices in accordance with a physician's instructions;

8.14.8.6 Assisting patients to carry out prescribed rehabilitation therapy between visits of the therapist; and

8.14.8.7 Instituting and maintaining bowel and bladder training.

8.15 In accordance with written job descriptions and with the standards in this document, nursing personnel shall enter in the patient's medical record:

8.15.1 The nursing care plan. This shall be reviewed at least every 7 days for skilled patients, every 14 days for ICF-A patients, and every 30 days for ICF-B patients, and revised at least every 30 days for skilled and ICF-A patients, and every 60 days for ICF-B patients, or in accordance with an alternative schedule which is justified and documented in the patient's medical record;

8.15.2 The nursing portion of the patient care plan. This shall be reviewed jointly by a licensed nurse and the patient's attending physician at least every 30 days for skilled and ICF-A patients, and every 60 days for ICF-B patients, or in accordance with an alternative schedule which the physician justifies and documents in the patient's medical record;

8.15.3 Clinical notes;

8.15.4 Progress notes, written at least every 30 days for skilled and ICF-A patients, and at least every 60 days for ICF-B patients, or in accordance with an alternative schedule which the nurse justifies and documents in the patient's medical record;

8.15.5 Summaries of conferences with a physician or other personnel;

8.15.6 The nursing portion of the discharge summary and discharge plan; and

8.15.7 A record of medication. After each administration of medication, the following shall be documented: name and strength of the drug, date and time of administration, dosage administered, route of administration, and signature of the licensed nurse administering the drug. (Initials may be used after the licensed nurse's full signature appears at least once on each page of the documentation.)

9.0 **Pharmaceutical Services**

9.1 The facility shall provide pharmaceutical services either directly or through written agreement.

9.2 The facility shall maintain the organization, management and operation of pharmaceutical services in accordance with a written organizational plan which shall describe the responsibility, authority and accountability relationships of personnel, the functional structure of the service, and the relationship of the pharmaceutical service to other services.

9.3 The facility shall have in writing and review annually policies, (including stop order policies), procedures and methods for obtaining, dispensing, storing, administering, and usage of medications and biologicals, developed with the advice of the Pharmaceutical Services Committee. The Committee shall consist of, but not be limited to, the medical director or a physician, the administrator, the director of nursing services, and either the staff pharmacist or the consultant pharmacist and a pharmacist issuing drugs to the facility. The Committee shall meet at least quarterly and document its activities, findings and recommendations.

9.4 The facility shall ensure that:

9.4.1 All medications are prescribed in writing and the prescription signed by a physician, and are administered by licensed or authorized personnel, in accordance with the State of New Jersey Medical and Nursing Practice Acts and the New Jersey Administrative Code for the State Board of Pharmacy;

9.4.2 Drug reactions and/or allergies are documented in the patient's medical record and on its outside front cover;

9.4.3 In administering medications, medication cards or other systems approved by the Department are used;

9.4.4 Medications prescribed for one patient are not administered to another patient except in emergencies (as defined in the facility's patient care policies), and such incidents are documented in an incident report;

9.4.5 Self-administration of medications by patients is not permitted except on written order of a physician;

9.4.6 Medications are released to patients upon discharge only on the written authorization of a physician, and are relabeled and repackaged by the pharmacist with directions for use, in accordance with the New Jersey Administrative Code for the State Board of Pharmacy. Documentation of released medications shall be entered in the patient's medical record;

9.4.7 Medication errors and drug reactions are immediately reported to the patient's attending physician, the pharmacist(s), the administrator and the director of nursing services, and an entry thereof made in the patient's medical record as well as on an incident report. The Pharmaceutical Services Committee shall review all incidents relating to drugs;

9.4.8 A current medication reference text and sources of information, determined by the Pharmaceutical Services Committee concerning drugs, their indications, actions, reactions, interactions, counterindications, cautions, precautions, and dosage, are provided in each nursing unit;

9.4.9 Emergency medication kits which are approved by the Pharmaceutical Services Committee and described in the pharmaceutical policy manual are kept at each nurses' station (but not kept under lock and key); and

9.4.10 Only non-legend drugs are maintained as stock, permanently labeled to include drug name, manufacturer, lot number, expiration date, and cautionary or accessory labeling.

9.5 If the facility maintains an institutional pharmacy, the pharmacy shall be licensed and the facility shall employ a pharmacist registered by the New Jersey State Board of Pharmacy.

9.6 If the facility does not have a licensed institutional pharmacy to provide direct pharmaceutical services, the facility shall appoint a pharmacist as consultant, and shall have written methods and procedures for obtaining prescribed medications and biologicals directly from a pharmacy licensed by the New Jersey State Board of Pharmacy. The phone number of the pharmacy shall be posted at each nurses station.

9.7 The staff or consultant pharmacist shall be responsible for the direction, provision and quality of the pharmaceutical services provided. He/she shall be responsible for, but not limited to, the following:

9.7.1 Together with the Pharmaceutical Services Committee, developing and maintaining written objectives, standards of practice, policies, a procedure manual and an organizational plan for the pharmaceutical service;

9.7.2 Participating in planning and budgeting for the pharmaceutical service;

9.7.3 Coordinating and integrating the pharmaceutical service with other patient care services;

9.7.4 Participating in staff committees, including, but not limited to, the Patient Care Policy, Evaluation, Pharmaceutical, and Infection Control Committees and providing consultation to the Discharge Planning Committee;

9.7.5 Maintaining working relationships with administration through conferences, written memoranda and other methods of exchanging information;

9.7.6 Assisting in the development of, and participating in, staff orientation and educational programs for the facility and the pharmaceutical service, and documenting these activities;

9.7.7 Preparing, reviewing, dating and signing the pharmacist consultation sheet in the medical record of each patient at least every 30 days, noting any problems such as interactions or wrong dosages;

9.7.8 Providing to the Pharmaceutical Services Committee a quarterly summary of the status of the facility's pharmaceutical services and an analysis of any incident reports relating to drug therapy.

9.7.9 Providing pharmaceutical guidance to other personnel responsible for patient care; and

9.7.10 Ensuring that:

9.7.10.1 The label of each patient's individual medication container is permanently affixed and clearly indicates the patient's full name, physician's name, prescription number, name and strength of drug, date of issue, manufacturer's expiration date of all time-dated medications, name, address and telephone

number of the pharmacy issuing the drug, lot number, manufacturer's name, and cautionary and/or accessory labels. If a unit dose system is used, cautionary instructions shall appear on the patient's record of medication;

9.7.10.2 Medications in containers having soiled, damaged, incomplete, illegible or makeshift labels are returned to the issuing pharmacist or pharmacy for relabeling, disposal, or destruction, and medications in containers having no labels are destroyed in accordance with state and federal laws;

9.7.10.3 Medications for individual patients are kept and stored in the original prescription containers, and there is no transferring between containers;

9.7.10.4 Medications requiring refrigeration are kept in a separate, locked box in the refrigerator, in a locked refrigerator, or in a refrigerator in the locked medication room, at or near the nurses' station. The refrigerator shall have a thermometer to indicate temperature in conformance with U.S.P. (United States Pharmacopoeia) requirements;

9.7.10.5 Poisons and medications for external use only are kept in a locked cabinet or room and separate from other medications;

9.7.10.6 Medications which the physician's written orders do not specifically limit as to time or number of doses are automatically stopped, in accordance with the stop order policies developed by the Pharmaceutical Services Committee.

9.7.10.7 Outdated medications or medications no longer in use are returned to the pharmacy and/or disposed of or destroyed within 30 days and in accordance with state and federal laws and regulations, and the action taken documented and signed in the patient's medical record. Action taken on controlled dangerous drugs shall also be documented and signed in a log or file kept for that purpose.

9.7.10.8 Medications and intravenous solutions having an expiration date are removed from use on that date, disposed of after such date, and the disposal documented, as prescribed by law; and

9.7.10.9 The drugs contained in the emergency medication kits are supplied in single dose ampules (if so manufactured) labeled with expiration dates, checked at least monthly or as otherwise specified in the pharmaceutical policy manual, and replaced when used or expired.

9.8 The control of drugs subject to the Controlled Dangerous Substances Act of 1970 shall be in full compliance with all federal and state laws and regulations concerning procurement, storage, dispensing, administration and disposition.

9.8.1 An individual record shall be maintained for each type and strength of medication subject to the aforementioned Act. The following shall be recorded: name of the patient receiving the medication, physician's name, prescription number, name and strength of the drug, date received from the pharmacy, date of administration, dosage administered, route of administration, signature of the licensed nurse administering the drug, amount of medication remaining, amount of medication wasted (when appropriate), and the signature of the nurse witnessing the destruction of medication wasted (when appropriate). At the termination of each tour of duty, the inventories shall be verified and the record shall be signed by both incoming and outgoing licensed nurses. (Exception: if a unit dose system is used, the consultant pharmacist is responsible for the control and accountability of medications).

9.8.2 The facility shall have written policies and procedures to be followed in the event that the inventories cannot be verified or drugs are lost, contaminated or destroyed. A report of any such incident shall be written and signed by the licensed nurses involved and any witnesses present, and copies shall be sent for review to the administrator, the director of nursing services, the consultant pharmacist, the pharmacy issuing drugs to the facility, and the Pharmaceutical Services Committee.

9.9 All medications shall be kept in locked storage areas.

9.9.1 Medications subject to the Controlled Dangerous Substances Act of 1970, Classes III, IV and V, shall be kept in a locked medication cabinet, medication room or mobile medication cart, and separate from non-controlled drugs.

9.9.2 Medications subject to the Controlled Dangerous Substances Act of 1970, Class II, shall be stored in a separate, locked box or drawer within the locked medication cabinet, medication room or mobile medication cart, and separate from non-controlled drugs.

9.9.3 Exceptions may be made to the storage requirements of medications subject to the aforementioned Act if the facility uses a unit dose system.

10.1 **Dietary Services**

10.1 The facility shall meet the daily nutritional needs of patients by providing dietary services directly or through written agreement. If a commercial food management firm provides dietary services, it shall be required to conform to the standards outlined herein.

10.2 The facility shall maintain the organization, management and operation of dietary services in accordance with a written organizational plan which shall describe the responsibility, authority and accountability relationships of personnel, the functional structure of the service, and the relationship of the dietary service to other services.

10.3 The facility shall provide:

10.3.1 Nutrients and calories for each patient, as ordered by a physician, based upon current recommended dietary allowances of the Food and Nutrition Board of the National Academy of Sciences, National Research Council, adjusted for age, sex, weight, physical activity, and therapeutic needs of the patient;

10.3.2 A current diet manual approved by the Patient Care Policy Committee, the dietitian and the Department, located in the dietary department and in each nursing unit;

10.3.3 Diets, served to patients, that are consistent with the diet manual;

10.3.4 Dietary service personnel on duty for a period of at least 12 hours daily; and

10.3.5 Designation of responsibility for observation and documentation of meals refused or missed.

10.4 All patients shall be encouraged to eat in the dining room, unless bedfast and/or ordered to the contrary by a physician in the medical care plan and so documented in the patient care plan.

10.5 The facility and personnel shall comply with the provisions of Chapter 12 of the New Jersey State Sanitary Code.

10.6 The facility shall ensure that the dietary service:

10.6.1 Selects food and drink and prepares menus with regard for the nutritional and therapeutic needs, cultural backgrounds, food habits and personal food preferences of patients;

10.6.2 Has written and dated menus, planned at least 14 days in advance by a dietitian, for all diets, and does not use the same menu more than once in one week;

10.6.3 Posts current menus with portion sizes in the food preparation area, and posts any changes in menus. Menus, with changes, shall be kept on file in the dietary department for at least 30 days;

10.6.4 Follows production sheets noting amounts of food and times of preparation;

10.6.5 Prepares and serves daily to patients at least three meals or their equivalent. At least two meals shall contain three or more menu items, one of which is or shall include a high quality protein food such as meat, fish, eggs or cheese. Each meal shall represent no less than 20% of the day's total calories, with at least 10% of distributed calories coming from protein;

10.6.6 Adheres to written policies, approved by the Department, regarding meal hours. No more than 14 hours shall elapse between an evening meal and breakfast the next morning, and the first meal shall not be served before 7 a.m.;

10.6.7 Provides between-meal and bedtime nourishments for each patient, unless contraindicated by a physician and documented in the patient care plan;

10.6.8 Offers substitute foods and drinks to all patients who refuse the food served at mealtimes. Such substitutes shall be of equivalent nutritional value;

10.6.9 Prepares food by cutting, chopping, grinding or blending to meet the needs of each patient; and

10.6.10 Provides self-help feeding devices.

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.

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10.8 The dietitian shall be responsible for the direction and quality of the dietary care provided. He/she shall be responsible for, but not limited to, the following:

10.8.1 Developing written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the dietary service;

10.8.2 Assessing the nutritional needs of each patient, preparing an individual dietary care plan, and reassessing the patient's response to dietary services at least every 30 days or in accordance with an alternative schedule which the dietitian justifies and documents in the patient's medical record;

10.8.3 Reviewing and approving all menus used;

10.8.4 Providing or recommending sources and use of standardized recipes, adjusted to appropriate yield;

10.8.5 Providing nutritional guidance and consultation to other patient care personnel;

10.8.6 Participating in developing, reviewing and revising the dietary portion of patient care plans;

10.8.7 Providing dietary counseling to patients and their families while the patient is in the facility and at the time of discharge;

10.8.8 Developing and maintaining written job descriptions for dietary personnel;

10.8.9 Recommending to the administrator the number and levels of dietary personnel to be employed; and

10.8.10 Assisting in selecting for employment, assigning duties to, supervising and evaluating all dietary personnel.

10.9 The facility shall appoint a full-time food service supervisor who, if not a dietitian, functions with scheduled consultation from a dietitian. Facilities of more than 240 patients shall employ a full-time food service supervisor and at least one full-time dietitian.

10.10 The food service supervisor, under the direction of a dietitian, shall be responsible for, but not limited to, the following:

10.10.1 Implementing written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the dietary service;

10.10.2 Participating in planning and budgeting for the dietary service, including developing methods of food cost control;

10.10.3 Coordinating and integrating the dietary service with other patient care services;

10.10.4 Participating in staff committees, including, but not limited to, the Patient Care Policy, Evaluation, Pharmaceutical, Discharge Planning and Infection Control Committees;

10.10.5 Maintaining working relationships with administration through conferences, written memoranda and other methods of exchanging information;

10.10.6 Assisting in the development of, and participating in, staff orientation and educational programs for the facility and the dietary service, and documenting these activities;

10.10.7 Maintaining a record of all patients, identified by name, location, diet order, and such other information as food likes and dislikes, allergies, and meal patterns when on a calculated diet. Such identification shall appear on each patient's tray or in the dining room;

10.10.8	Ensuring that therapeutic diets as ordered by a physician are served, and that no patient receives a therapeutic diet except as ordered by a physician;
10.10.9	Establishing and maintaining a method of recording and transmitting diet orders and changes received from the nursing service;
10.10.10	Maintaining a file of recipes for menu items, adjusted to yield, which shall be used in preparing foods listed on the posted menus;
10.10.11	Recommending the quantity, kinds and variety of food and supplies to be purchased; and
10.10.12	Providing a monthly summary, including, but not limited to, the following:
10.10.12.1	Records of weekly menus of all diets served to patients; and
10.10.12.2	The numbers and kinds of diets served daily to patients.
10.11	The dietitian or consultant dietitian shall enter in the patient's medical record:
10.11.1	The dietary care plan. This shall be reviewed, and revised as necessary, by the dietitian or consultant dietitian at least every 30 days for skilled and ICF-A patients, and every 60 days for ICF-B patients, or in accordance with an alternative schedule which he/she justifies and documents in the patient's medical record;
10.11.2	Clinical notes;
10.11.3	Progress notes, written at least every 30 days or in accordance with an alternative schedule which the dietitian or consultant dietitian justifies and documents in the patient's medical record;
10.11.4	Summaries of conferences with a physician or other personnel; and
10.11.5	The dietary portion of the discharge summary and discharge plan.

11.0 Rehabilitation Services

11.1 The facility shall provide physical and occupational therapy, speech pathology and audiology services directly or through written agreement, when prescribed by a physician. Such services shall be performed on the premises for skilled patients.

11.2 The facility shall maintain the organization, management and operation of rehabilitation therapy services in accordance with a written organizational plan which shall describe the responsibility, authority and accountability relationships of personnel, the functional structure of the service, and the relationship of the rehabilitation service to other services.

11.3 The facility shall appoint a supervisor for each rehabilitation service offered, who shall be responsible for the direction, provision and quality of the rehabilitative care provided. He/she shall be responsible for, but not limited to, the following:

11.3.1 Developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the rehabilitation service;

11.3.2 Participating in planning and budgeting for the rehabilitation service, including recommending to the administrator the number and levels of rehabilitation personnel to be employed;

11.3.3 Coordinating and integrating the rehabilitation service with other patient care services;

11.3.4 Participating in staff committees, including, but not limited to, the Patient Care Policy, Evaluation, Pharmaceutical, Discharge Planning and Infection Control Committees;

11.3.5 Maintaining working relationships with administration through conferences, written memoranda and other methods of exchanging information;

11.3.6 Developing and maintaining written job descriptions for rehabilitation personnel;

11.3.7 Assisting in selecting for employment, assigning duties to, supervising and evaluating all rehabilitation service personnel;

11.3.8 Assisting in the development of, and participating in, staff orientation and educational programs for the facility and the rehabilitation service, and documenting these activities; and

11.3.9 Ensuring that the rehabilitation personnel assess the rehabilitation needs of each patient upon orders of a physician, prepare an individual rehabilitation care plan, and reassess the patient's response to rehabilitation services at least every 30 days for skilled and ICF-A patients and every 60 days for ICF-B patients, or in accordance with an alternative schedule which the therapist, speech pathologist or audiologist justifies and documents in the patient's medical record.

11.4 Each therapist, speech pathologist and audiologist shall be responsible for, but not limited to, the following:

11.4.1 Assessing the degree of functioning and disability of the patient receiving the service, preparing an individual rehabilitation care plan, and, with a physician, reassessing the patient's response to treatment at least every 30 days for skilled and ICF-A patients and every 60 days for ICF-B patients, or in accordance with an alternative schedule which the therapist, speech pathologist or audiologist justifies and documents in the patient's medical record;

11.4.2 Providing treatment services as specified in the rehabilitation care plan, and reporting the patient's responses to the physician within 14 days of the initiation of rehabilitation therapy;

11.4.3 Providing rehabilitation guidance and consultation to other patient care personnel;

11.4.4 Developing a maintenance rehabilitation regimen for the patient when approved by the physician, instructing other patient care personnel in its procedures, and reevaluating and revising the maintenance regimen, as indicated in the rehabilitation care plan; and

11.4.5 Participating in developing, reviewing and revising the rehabilitation portion of the patient care plans of patients receiving rehabilitation services.

11.5 Each therapist, speech pathologist and audiologist providing services to the patient shall enter in the patient's medical record:

11.5.1 The rehabilitation care plan. This shall be reviewed, and revised as necessary, by the therapist, speech pathologist or audiologist and by a physician at least every 30 days for skilled and ICF-A patients and every 60 days for ICF-B patients, or in accordance with an alternative schedule justified and documented in the patient's medical record;

11.5.2 Clinical notes;

11.5.3 Progress notes, written at least every 30 days or in accordance with an alternative schedule which the therapist, speech pathologist or audiologist justifies and documents in the patient's medical record;

11.5.4 Summaries of conferences with a physician or other personnel; and

11.5.5 The rehabilitation portion of the discharge summary and discharge plan.

12.0 <u>Social Work Services</u>

12.1 The facility shall provide social services directly or through written agreement.

12.2 The facility shall maintain the organization, management and operation of social work services in accordance with a written organizational plan which shall describe the responsibility, authority and accountability relationships of personnel, the functional structure of the service, and the relationship of the social work service to other services.

12.3 The facility shall ensure visual and auditory privacy for social service interviews with patients and their families and/or sponsors and/or guardians.

12.4 The facility shall appoint a social worker, or a designee who receives on-site consultation from a social worker. A social worker or designee shall provide social work services in the facility one hour per week for every six patients. Facilities of 210 patients shall have one full-time social worker or full-time designee. Additional social work time shall be provided in the facility proportionate to the number of patients over 210, at a ratio of one additional hour per six additional patients. Social work consultation to the designee shall be at least two hours per week in facilities with more than 60 patients. Facilities of 60 or fewer patients shall have four hours of social work consultation per month.

12.5 The social worker shall be responsible for, but not limited to, the following:

12.5.1 Providing social work guidance and consultation to other patient care personnel;

12.5.2 Ensuring that social service personnel assess the social needs of each patient, reassess each patient's social service needs at least every six months, and prepare an individual social service care plan if the assessment or reassessment indicates a need for social services;

12.5.3 Developing written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the social work service. This shall include policies and procedures for the use and coordination of social services available through hospitals, community health programs and community social agencies;

12.5.4 Developing and maintaining written job descriptions for social service personnel;

12.5.5 Recommending to the administrator the number and levels of social service personnel to be employed; and

12.5.6 Assisting in selecting for employment, assigning duties to, supervising and evaluating all social service personnel.

12.6 The social worker, or the designee under the direction of the social worker, shall be responsible for the direction, provision and quality of the social services provided. He/she shall be responsible for, but not limited to, the following:

12.6.1 Implementing written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the social work service;

12.6.2 Participating in planning and budgeting for the social work service;

12.6.3 Coordinating and integrating the social work service with other patient care services;

12.6.4 Participating in staff committees, including, but not limited to, the Patient Care Policy, Evaluation, and Discharge Planning Committees;

12.6.5 Maintaining working relationships with administration through conferences, written memoranda and other methods of exchanging information;

12.6.6 Assisting in the development of, and participating in, staff orientation and educational programs for the facility and the social work service, and documenting these activities;

12.6.7 Assessing each patient to identify any social needs or problems he/she may have in the facility and/or with his/her family, reassessing the patient's social service needs at least every six months, and preparing an individual social service care plan if the assessment or reassessment indicates a need for social services;

12.6.8 Providing ongoing individual and/or group counseling of patients, their next of kin and/or sponsors and/or guardians, and writing clinical and progress notes;

12.6.9 Obtaining social services as specified in the social service care plan;

12.6.10 Contacting social and other agencies for information, referrals and services; and

12.6.11 Participating in developing, reviewing and revising the social service portion of patient care plans.

12.7 The social worker or designee shall enter in the patient's medical record:

12.7.1 A social service assessment initiated upon admission and completed within seven days, after an initial interview with the patient and/or his/her family, sponsor and/or guardian. This shall include a social history, including family background, education, employment, interests, activities, organizational memberships, psychosocial functioning, relationships with family and friends, and reason for, and reactions to, placement in the facility. The assessment shall be reviewed and revised at least every six months;

12.7.2 The social service care plan, if the initial or subsequent assessment indicates a need for social services. This shall be reviewed at least every six months and revised as necessary;

12.7.3 Clinical notes of counseling provided;

12.7.4 Progress notes if the patient is receiving social services. These shall be written at least every six months and shall summarize changes in the patient's condition and feelings;

12.7.5 All referrals to outside resources, and documentation of follow-up;

12.7.6 Summaries of conferences with a physician or other personnel; and

12.7.7 The social service portion of the discharge summary and discharge plan.

12.8 The social worker or designee may file information relating to the patient apart from the patient's medical record, with an entry in the record indicating the availability of the additional material upon the social worker's or designee's approval.

13.0 Patient Activities Services

13.1 The facility shall provide a planned, diversified program of patient activities.

13.2 The facility shall maintain the organization, management and operation of patient activities services in accordance with a written organizational plan which shall describe the responsibility, authority and accountability relationships of personnel, the functional structure of the service, and the relationship of the patient activities service to other services.

13.3 The facility shall ensure that:

13.3.1 A diversity of physical, social, intellectual, spiritual, cultural, and recreational activities is available, consisting of individual, group, and independent activities on seven days of the week, including evenings;

13.3.2 Provisions are made for relatives and friends of patients to participate in patient life;

13.3.3 Patients have the opportunity to communicate with members of the community, to participate in community activities and to utilize community resources, unless contraindicated by their physician in the patient's medical record;

13.3.4 Indoor and outdoor recreation is provided;

13.3.5 Methods of transportation are provided for patients to and from destinations in the community; and

13.3.6 Patients have the opportunity to participate in the planning and administration of their lives, such that provisions are made for encouraging the establishment of a Patient Council made up of patients of the facility.

13.4 The facility shall appoint a patient activities coordinator who shall provide patient activities services in the facility at least ten hours per week for every 15 patients. Facilities of more than 60 patients shall have a full-time or full-time equivalent coordinator. Additional patient activities time shall be provided proportionate to the number of patients over 60.

13.5 If the patient activities coordinator does not meet the requirements in 1.50, a patient activities consultant shall be appointed. He/she shall provide at least four hours of consultation in the facility per month until the activities coordinator meets the requirements, a period not to exceed two years.

13.6 The patient activities coordinator shall be responsible for the direction and quality of the patient activities provided. He/she shall be responsible for, but not limited to, the following:

13.6.1 Developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the patient activities service;

13.6.2 Participating in planning and budgeting for the patient activities service, including recommending to the administrator the number and levels of patient activities personnel to be employed, and the equipment and supplies to be purchased;

13.6.3 Coordinating and integrating the patient activities service with other patient care services in the facility, and with services in the community;

13.6.4 Participating in staff committees, including, but not limited to, the Patient Care Policy, Evaluation, and Discharge Planning Committees;

13.6.5 Maintaining working relationships with administration through conferences, written memoranda and other methods of exchanging information;

13.6.6 Developing and maintaining written job descriptions for patient activities personnel;

13.6.7 Assisting in selecting for employment, assigning duties to, supervising and evaluating all patient activities personnel;

13.6.8 Assisting in the development of, and participating in, staff orientation and educational programs for the facility and the patient activities service, and documenting these activities;

13.6.9 Maintaining a current record of community services, resources, programs and materials, accessible to staff and to patients and their relatives and friends;

13.6.10 Developing a written monthly activities schedule at least one month in advance;

13.6.11 Posting the current monthly activities schedule in each nursing unit and where it can be read by patients, visitors and staff;

13.6.12 Ascertaining from the attending physician's medical orders those patients who are able to participate in the activities program, and any limitations to their participation;

13.6.13 Assessing the activities needs of each patient within seven days of admission, preparing an individual patient activities care plan, and reassessing the patient's response to patient activities at least every 90 days after reviewing with the patient his/her participation in the activities program;

13.6.14 Providing patient activities guidance and consultation to other patient care personnel;

13.6.15 Organizing and meeting with a Patient Activities Committee of patients to develop activity programs;

13.6.16 Participating in developing, reviewing and revising the patient activities portion of patient care plans; and

13.6.17 Providing a record of the type and frequency of activities held, and the number of patients participating in the activities program.

13.7 The patient activities coordinator shall enter in the patient's medical record:

13.7.1 The patient activities care plan. This shall be reviewed by the patient activities coordinator at least every 90 days and revised as necessary;

13.7.2 A record of the types and number of activities in which the patient participates;

13.7.3 Progress notes, written at least every 90 days, after reviewing with the patient his/her participation and progress in patient activities;

13.7.4 Summaries of conferences with a physician or other personnel; and

13.7.5 The patient activities portion of the discharge summary and discharge plan.

14.0 Dental Services

14.1 The facility shall make available dental services, including, but not limited to, examinations, oral prophylaxis, and emergency dental care to relieve pain and infection, either directly or through written agreement. *

14.1.1 Examination and oral prophylaxis shall be provided according to a schedule established by the patient's dentist. *

14.2 The facility shall appoint a consultant or staff dentist who shall be responsible for, but not limited to, the following:

14.2.1 Developing and implementing written dental service and oral hygiene policies and procedures for the care of patients; and

14.2.2 Providing staff education for nursing and other personnel in implementing the dental service and oral hygiene policies and procedures.

14.3 The facility shall ensure that:

14.3.1 Arrangements for patients who do not have a private dentist are made for annual examination, oral prophylaxis and emergency dental care; and

14.3.2 Arrangements are made for transportation for routine and emergency dental services.

14.4 The dentist who examines the patient shall be able to provide treatment, unless the examination indicates that a specialist is needed.

14.5 The consultant or staff dentist shall enter in the patient's medical record:

14.5.1 An admission record of the patient's dental status, entered within 180 days after admission; and

14.5.2 Records of dental care provided.

* Revised - Effective 7/5/79

15.0 Laboratory, Radiological and Diagnostic Services

15.1 The facility shall provide laboratory, radiological and diagnostic services directly, or through written agreement with facilities licensed or approved by the Department to provide such services.

15.2 The facility shall establish written policies to ensure that its patients receive laboratory, radiological and diagnostic services ordered by a physician.

15.3 If a facility provides inpatient laboratory, radiological and diagnostic services, it shall comply with all federal and state laws regulating these services.

15.4 All laboratory, radiological and diagnostic services shall be provided to patients only on order of a physician.

15.5 Findings of such services shall be reported in writing to a physician.

15.6 The facility shall arrange transportation to and from the service.

15.7 Signed and dated reports of clinical laboratory, x-ray and other diagnostic services shall be entered in the patient's medical record.

16.0 **Patient Rights**

16.1 The facility shall establish written policies regarding the rights and responsibilities of patients and shall be responsible for developing and adhering to procedures implementing such policies. These policies and procedures shall be available to patients and their next of kin and/or sponsors and/or guardians, and to each member of the facility's staff. They shall be posted in a public place in the facility and be made available to the public.

16.2 The staff of the facility shall be trained to implement these policies and procedures, as specified in the staff education plan.

16.3 The facility shall comply with all applicable state and federal statutes, rules and regulations concerning patient rights, including N.J.S.A. Chapter 120, P.L. 1976, and the standards in this document.

16.4 Patient rights, policies and procedures shall ensure that, as a minimum, each patient admitted to the facility:

16.4.1 Is informed of these rights, as evidenced by his/her written acknowledgment prior to or at the time of admission and during stay, and is given a statement of the facility's rules and regulations, and an explanation of the patient's responsibility to obey all regulations of the facility and to respect the personal rights and private property of other patients;

16.4.2 Is informed, and is given a written statement prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by sources of third party payments or not covered by the facility's basic per diem rate. This statement shall include the payment, fee, deposit, and refund policy of the facility;

16.4.3 Is allowed to retain the services of his/her personal physician at his/her own expense or under a health care plan; is assured of medical care; is informed by a physician of his/her complete and current medical condition unless

medically contraindicated (as documented, by a physician, in the medical record), in which case the physician shall inform the patient's next of kin and/or sponsor and/or guardian; is afforded the opportunity to participate in the planning of his/her care and treatment; to refuse medication and treatment after being informed of and understanding the consequences of such actions, and to refuse to participate in experimental research, (but if he/she chooses to participate, his/her informed written consent shall be obtained);

16.4.4 Is transferred or discharged only for medical reasons or for his/her welfare or that of other patients, upon the written order of the patient's attending physician, or for non-payment for the patient's stay (except as prohibited by sources of third party payment), and such actions are documented in the patient's medical record, except in an emergency situation, in which case the administrator shall notify the physician and the next of kin and /or sponsor and/or guardian immediately, and record the reason for the transfer in the patient's medical record. If a transfer or discharge on a nonemergency basis is requested by the facility, the patient, or in the case of an adjudicated mentally incompetent patient, the next of kin and/or sponsor and/or guardian, shall be given at least 30 days advance notice of such transfer or discharge;

16.4.5 Is encouraged and assisted, throughout the period of stay, to exercise rights as a patient and as a citizen, and to this end may voice grievances on behalf of himself/herself or others, has a right to action for damages or other relief for deprivations or infringements of the right to treatment and care established by any applicable statute, rule, regulation, or contract, and has the right to recommend changes in policies and services to facility personnel and/or to outside representatives of the patient's choice, free from restraint, interference, coercion, discrimination or reprisal. The administrator shall provide all patients and/or next of kin and/or sponsors and/or guardians with the name, address, and telephone numbers of:

Director of Licensing, Certification and Standards
Division of Health Facilities Evaluation
New Jersey State Department of Health
John Fitch Plaza
P.O. Box 1540
Trenton, NJ 08625
Telephone: (800) 792-9770

and

Office of Nursing Home Ombudsman
Department of Community Affairs
State Division on Aging
363 West State Street
Trenton, NJ 08625
Telephone: (800) 792-8820

where complaints may be lodged. These telephone numbers shall be conspicuously posted in the facility at every public telephone and on all bulletin boards used for posting public notices;

16.4.6 Is free from mental and physical abuse, and free from chemical and physical restraints except those restraints authorized by a physician for a specified and limited period of time or in an emergency. (See sections 6.6.15 - 6.6.15.6.) Drugs and other medications shall not be used for punishment, for convenience of facility personnel, or in quantities that interfere with a patient's rehabilitation or living activities;

16.4.7 Is assured security in storing personal possessions and confidential treatment of his/her personal and medical records, and shall approve or refuse their release to any individual outside the facility, except in the case of the patient's transfer to another health care institution, or as required by law or third party payment contract;

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

16.4.9 Is not required to perform services for the facility;

16.4.10 May associate and communicate privately with persons of his/her choice, may join with other patients or individuals within or outside the facility to work for improvements in patient care, may send and receive personal mail unopened, and, upon his/her request, shall be given assistance in the reading and writing of correspondence. The facility shall, with the consent of the patient being visited, permit citizens, legal services programs, employees of the Department of the Public Advocate, and employees and volunteers of the Office of the Nursing Home Ombudsman Program in the Department of Community Affairs, full and free access at a reasonable hour to the facility in order to visit with, and make personal, social and legal services available to, all patients;

16.4.11 May participate in facility activities, and meet with, and participate in activities of, social, religious and community groups at his/her discretion. Arrangements shall be made, at the patient's expense, for attendance at religious services of his/her choice when requested;

16.4.12 Is allowed to leave the facility during the day if his/her physician so approves and so indicates in the patient's medical record. A sign-out sheet shall record the patient's whereabouts at these times. Special arrangements between a patient and the facility shall be made in advance for overnight or longer stays away from the facility;

16.4.13 May retain and use personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients. If the patient has property on deposit with the facility, he/she shall have daily access to such property during specific periods established by the facility, and at a reasonable hour;

16.4.14 Has opportunity for interaction with members of the opposite sex; if married, is assured privacy for visits by his/her spouse; if both spouses are patients in the facility, they shall be permitted to share a room unless medically contraindicated (as documented, by a physician, in the medical record);

16.4.15 Is allowed, or his/her next of kin, sponsor or guardian is allowed, to manage the patient's personal financial affairs, or is given at least a quarterly written statement of financial transactions made on his/her behalf should the facility accept his/her written delegation of this responsibility. The written delegation of responsibility shall be reviewed annually and witnessed by a person who is unconnected with the facility, its operations, and its personnel, and shall be included in the medical record. The financial statement shall account for all the patient's property on deposit at the beginning of the quarter, all deposits and withdrawals transacted during the quarter, (substantiated by receipts given to the patient or his/her next of kin and/or sponsor and/or guardian), and the property on deposit at the end of the quarter;

16.4.16 Is allowed daily visiting hours at a reasonable hour and, if critically ill, is allowed visits from his/her next of kin and/or sponsor and/or guardian at any time, unless medically contraindicated (as documented by a physician in the medical record). The facility shall conspicuously post that visiting hours are from 8:00 a.m. to 8:00 p.m. daily. Members of the clergy shall be notified by the facility at the patient's request, and shall be admitted at the request of the patient and/or next of kin, sponsor and/or guardian at any time. Privacy shall be ensured for visits with family, friends, clergy, social workers, or for professional or business purposes;

16.4.17 Is allowed unaccompanied access to telephones at a reasonable hour, both to make and to receive confidential calls, and has the right to a private phone at his/her expense;

16.4.18 Is not required to go to bed before the end of visiting hours, unless ordered by a physician and documented in the patient's medical record;

16.4.19 Is assured of exercising civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient. Knowledge of available choices shall not be infringed and the facility shall encourage and assist in the exercise of these rights;

16.4.20 Is not the object of discrimination with respect to participation in recreational activities, meals or other social functions because of age, race, religion, sex or nationality. The patient's participation may be restricted or prohibited if recommended by the attending physician in the patient's medical record, and consented to by the patient;

16.4.21 Is not deprived of any constitutional, civil and/or legal right solely by reason of admission to the facility; and

16.4.22 Is allowed to discharge himself/herself from the facility upon presentation of a written release and, if the patient is an adjudicated mental incompetent, upon the written consent of his/her next of kin and/or sponsor and/or guardian. In such a case, the facility is free from any responsibility for the patient upon his/her discharge.

17.0 Medical Records

17.1 The facility shall maintain a complete medical record for each patient, filed in the nursing unit in which the patient is located, and containing documentation of all services provided.

17.2 The facility shall assign supervisory responsibility for the medical record service to a full-time employee, who, if not a medical record practitioner, functions with consultation from a person so qualified.

17.3 The complete medical record shall include, but not be limited to, the following:

17.3.1 Patient identification data, including name, date of admission, address, date of birth, race and religion (optional), sex, referral source, financial identification, and next of kin, sponsor and/or guardian;

17.3.2 Names of the patient's attending physician and designated alternate(s);

17.3.3 The patient's signed acknowledgement that he/she has been informed of patient rights;

17.3.4 A physician's signed and dated admission history, report of physical examination, and medical care plan;

17.3.5 All initial and subsequent orders by a physician, including frequency and modality of rehabilitation therapy;

17.3.6 A record of visits and progress notes by the physician;

17.3.7 A patient care plan, included at the time of discharge;

17.3.8 A care plan for each service providing care to the patient;

17.3.9 A social service assessment;

17.3.10 Clinical notes;

17.3.11 Progress notes;

17.3.12 A pharmacist consultation sheet. Drug reactions and/or allergies shall also appear on the outside front cover of the medical record;

.7.3.13 A record of medications administered, including the name and strength of the drug, date and time of administration, dosage administered, route of administration and signature of the licensed nurse administering the drug. (Initials may be used after the licensed nurse's full signature appears at least once on each page of the documentation);

.7.3.14 Reports of clinical laboratory, x-ray and other diagnostic services;

.7.3.15 Reports of accidents and incidents;

.7.3.16 A record of any treatment, medication or service refused by the patient, including a physician's visit;

.7.3.17 Admission dental record and records of subsequent dental care provided;

.7.3.18 Summaries of services provided at other health and health-related facilities;

.7.3.19 The quarterly financial statement, the written delegation of responsibility (if any), and a record of the clothing, personal effects, valuables, funds and other property deposited by the patient with the facility for safekeeping, signed by the patient and his/her next of kin and/or sponsor and/or guardian, and substantiated by receipts given to the patient, his/her next of kin and/or sponsor and/or guardian;

.7.3.20 Reports of podiatric services, eye examinations, and auditory testing;

.7.3.21 Summaries of conferences and consultations;

.7.3.22 Documentation of any medication released to the patient upon discharge; and

.7.3.23 A discharge summary and discharge plan.

.7.4 A unit record system shall be maintained, in which the patient's complete medical record is filed as one unit.

.7.5 All orders for treatment, medication and/or therapeutic diets shall be written, dated, and signed by the physician. All entries, including progress notes, contained in the patient's medical record shall be typewritten or written in ink, legible, and dated and signed by the recording person.

17.6 All medical records shall be preserved in accordance with N.J.S.A. 26:8-5 et seq.

17.7 Medical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern the use and removal of records and conditions for release of information. The written consent of the patient or his/her next of kin and/or sponsor and/or guardian shall be obtained for release of information not required by law or regulation.

17.8 Upon transfer of a patient to another health care facility, a copy, summary, or abstract of the patient's medical record shall be sent to the receiving facility with the written consent of the patient or his/her next of kin and/or sponsor and/or guardian. In the event of denial of permission, a copy of the written denial shall be kept in the patient's medical record at the facility. If the patient, next of kin, sponsor or guardian refuses to sign the denial of permission, a witnessed, written statement by a staff member to that effect shall be included in the patient's medical record.

17.9 The medical record of a discharged patient shall be completed and signed within 30 days of discharge.

17.10 If the facility ceases to operate, it shall notify the Department in writing at least 14 days before cessation of operation, regarding how and where medical records shall be stored.

18.0 **Patient Care Statistics**

18.1 The facility shall maintain the following written records in a place, form and system approved by the Department:

18.1.1 An admission/discharge register consisting of a daily chronological listing of patients admitted and discharged, including name of patient, age, sex, date of birth, diagnosis, level of care needed, place from which patient is admitted or transferred (for admissions), and place to which patient is discharged or transferred (for discharges); and

18.1.2 A daily census record indicating total admissions, total discharges, and total deaths, with cumulative figures for each month and each year.

18.2 The facility shall submit a completed questionnaire entitled "Long-Term Care Facilities Statistical Report," supplied by the Department. The questionnaire is to be submitted annually during the month of July.

19.0 Financial Data

19.1 Upon development of a uniform cost reporting system approved by the Health Care Administration Board, the facility shall adopt and maintain that system, from which reports will be prepared to meet the requirements of the Commissioner, as stated in Chapter 136, Laws of New Jersey 1971, Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq.

19.2 An annual financial report shall be submitted to the Department and shall include a statement of income and expenditure by unit of service.

20.0 <u>Discharge Planning</u>

20.1 The facility shall establish and implement a discharge planning program and shall require physicians to participate in the program.

20.2 A Discharge Planning Committee appointed by the administrator shall develop written discharge planning objectives, policies and procedures, approved by the Department, which shall describe:

20.2.1 The functions of the person or persons responsible for discharge planning and his/ her or their authority;

20.2.2 The time period, not to exceed seven days following admission, in which each patient's need for discharge planning is determined. The patient's attending physician shall indicate in the patient's medical record anticipated length of stay and potential discharge problems;

20.2.3 The maximum time period that may elapse before a reevaluation of each patient's discharge plan is made;

20.2.4 The manner in which the facility shall utilize a multidisciplinary team approach in discharge planning, including the patient and his/her next of kin and/or sponsor and/or guardian. The social work consultant shall be available; and

20.2.5 The methods used to involve the patient and his/her next of kin and/or sponsor and/or guardian in discharge planning.

20.3 A person or persons designated by the administrator shall develop, implement and maintain the discharge planning program. He/she or they shall be responsible for, but not limited to, performing and documenting the following:

20.3.1 Interviewing each patient upon admission and reviewing his/her medical record for possible discharge problems;

20.3.2 Evaluating needs and developing discharge planning goals for each patient;

20.3.3 Developing the patient's discharge plan, in collaboration with the attending physician, the multidisciplinary team and other personnel involved in the patient's care;

20.3.4 Making referrals to agencies involved in follow-up care;

20.3.5 Coordinating services within the facility and with outside agencies to ensure continuity of care; and

20.3.6 Developing a staff educational program on discharge planning which shall include, but not be limited to, orientation of each new employee involved in patient care, to the objectives and functions of discharge planning and to the role of the staff.

20.4 Education and involvement of the patient and his/her next of kin and/or sponsor and/or guardian in discharge planning shall be directed toward:

20.4.1 Understanding illness, disability and needed treatment;

20.4.2 Management of finances, if requested by the patient, next of kin and/or sponsor and/or guardian;

20.4.3 Implementation of self-care and treatment measures following discharge; and

20.4.4 Understanding reasons for transfer to another facility or home.

20.5 The discharge summary and discharge plan shall incorporate the discharge summaries and discharge plans for each service that the patient receives.

20.6 The Discharge Planning Committee shall annually evaluate in writing the discharge planning program. The evaluation shall describe the effect of the program upon patients, personnel, the facility, and costs, and the status of the program in meeting discharge planning objectives.

20.7 Evaluation shall be performed both retrospectively (assessment of patients who have been discharged) and concurrently (assessment of patients currently in the facility).

21.0 Evaluation

21.1 A written plan for audit and evaluation of patient care shall be developed annually by the facility and submitted, upon request, to the Department for approval. The plan shall specify the personnel to be involved in the evaluation process and the schedule for evaluation procedings, and shall provide for ongoing monitoring of staff and program activities and for audit of patient medical records.

21.2 A multidisciplinary Evaluation Committee shall be appointed by, and accountable to, the governing authority. The Committee shall be responsible for, but not limited to, the following:

21.2.1 Annual review of staff qualifications;

21.2.2 Evaluation of the effect on the facility of policies, procedures, and administrative practices;

21.2.3 Annual review of patient care statistics;

21.2.4 Annual review of staff orientation and educational programs;

21.2.5 Evaluation of the processes by which medical care and services are delivered, staffing patterns, maintenance of physical plant and equipment, and reports of infection control; and

21.2.6 Audit of patient medical records on an ongoing basis by means of:

21.2.6.1 Establishment of objective criteria for evaluating each service providing patient care;

21.2.6.2 Review of patient medical records for their conformity to established criteria; and

21.2.6.3 Recording of deficiencies found.

21.3 Based upon the findings of evaluation, audit and review, the Evaluation Committee shall annually select for study at least one topic related to patient care or facility operation. At least one such medical care evaluation study shall be completed each year.

21.4 Reports of the activities of all committees in the facility shall be made available to the Evaluation Committee.

21.5 The Evaluation Committee shall prepare at least an annual written report of its findings, including recommendations for corrections or improvements, which shall be submitted to the governing authority.

21.6 The administrator shall, with the approval of the governing authority, implement measures to ensure that corrections or improvements are made.

22.0 Infection Control

22.1 The facility shall establish a multidisciplinary Infection Control Committee, consisting of at least the medical director, the administrator, the director of nursing services, and the staff or consultant pharmacist. A representative of each service offered by the facility shall serve on the Committee at least on a consultative basis.

22.2 The Committee shall be responsible for, but not limited to, the following:

22.2.1 Development of a definition of nosocomial infections;

22.2.2 In conformance with Chapter 12 of the New Jersey State Sanitary Code, development and implementation of a system for investigating reporting, evaluating and maintaining records of infections among patients and personnel, including respiratory, gastrointestinal, surgical wound, skin, and urinary tract infections, septicemias, and infections related to the use of intravascular catheters. Recorded data on all infections shall include identification and location of the patient or staff member, date of admission or employment, date of onset of infection, type of infection, cultures taken and their results when known, any antibiotics or other medications administered, and name of the physician responsible for the care of the patient or staff member; and

22.2.3 Development of written policies and procedures, approved by the Department, for cleaning, disinfection and sterilization practices and techniques used in the facility, including, but not limited to, the following:

22.2.3.1 Care of utensils, instruments, solutions, dressings, articles and surfaces;

22.2.3.2 Techniques to be used during each patient contact, including handwashing before and after caring for a patient;

22.2.3.3 Criteria for isolation of patients, and isolation procedures;

22.2.3.4 Procedures for care of urinary catheters, intravenous catheters, respiratory therapy equipment, and other devices that provide a portal of entry for pathogenic microorganisms;

22.2.3.5 A regimen for the prevention and treatment of decubitus ulcers;

22.2.3.6 Selection, storage, use and disposition of non-disposable patient care items; and

22.2.3.7 Selection, storage, use and disposition of disposable patient care items. Disposable items shall not be reused; and

22.2.3.8 Selection, storage, use and disposition of hypodermic needles and syringes, in accordance with N.J.S.A. 2A:170-25.17.

22.3 Each service in the facility shall develop written infection control policies and procedures for that service, using the policies and procedures developed by the Infection Control Committee.

22.4 No employee who contracts a communicable disease shall be permitted to return to work until authorized in writing to do so by a physician.

22.5 Written reports of state and local sanitary inspections, including cultures taken on food, equipment and personnel, shall be sent to the Infection Control Committee for evaluation and corrective action.

23.0 Housekeeping Services

23.1 The facility shall maintain the organization, management and operation of housekeeping services in accordance with a written organizational plan which shall describe the responsibility, authority and accountability relationships of personnel, the functional structure of the service, and the relationship of the housekeeping service to other services.

23.2 A full-time supervisor of housekeeping services shall be appointed by, and accountable to, the administrator.

23.3 The supervisor of housekeeping services shall be responsible for, but not limited to, the following:

23.3.1 Developing a written work plan for cleaning operations and categorization as to daily, weekly, monthly or annual assignment for each area of the facility;

23.3.2 Assisting in selecting for employment, assigning duties to, supervising and evaluating all housekeeping personnel;

23.3.3 Training housekeeping personnel in procedures of cleaning, including the use, cleaning and care of equipment;

23.3.4 Developing procedures for selection and use of housekeeping and cleaning products and equipment; and

23.3.5 Evaluating housekeeping services.

23.4 The facility shall comply with the provisions of Chapter 12 of the New Jersey State Sanitary Code and with the following:

23.4.1 The facility and its contents shall be free from dust, dirt and debris;

23.4.2 Non-skid wax shall be used on all waxed floors;

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

23.4.4 Throw rugs or scatter rugs shall not be used in the facility;

23.4.5 All mechanical equipment shall be in working order, covered to protect from contamination, and accessible for cleaning and inspection;

23.4.6 All equipment shall have unobstructed space provided for operation;

23.4.7 All equipment and materials necessary for cleaning, disinfection and sterilization shall be provided;

23.4.8 Thermometers shall be maintained in refrigerators and storerooms used for perishable items;

23.4.9 All poisonous and toxic materials shall be identified, labeled and stored in a locked cabinet or room that is used for no other purpose;

23.4.10 Pesticides shall be applied so as to prevent contamination to patients and food. Vapona (insecticidal) strips shall not be used anywhere in the facility;

23.4.11 Articles in storage shall be elevated from the floor to facilitate cleaning and eliminate rodent harborages;

23.4.12 Unobstructed aisles shall be provided between articles in storage;

23.4.13 A program shall be maintained to keep rodents, insects, vermin, birds, animals, dust, and contamination out of the facility;

23.4.14 Insect and rodent harborages shall be eliminated from the facility;

23.4.15 Toilet tissue shall be provided at each toilet at all times;

23.4.16 Solid or liquid waste, garbage and trash shall be disposed of or stored in a manner approved by the Department and so as to prevent fire, contamination or transmission of disease. Solid waste shall be stored in insect and rodent-proof, fire-proof, non-absorbent, watertight containers with tight-fitting covers;

23.4.17 Draperies, upholstery and other fabrics or decorations shall be fire-resistant and flameproof; and

23.4.18 All patient areas shall be free from noxious odors.

23.5 If a commercial housekeeping service is used, it shall be required to maintain at least the standards outlined herein.

23.6 Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and handwashing facilities shall not exceed 110°F (43°C).

23.7 The administrator shall appoint a person responsible for linen and laundry services in the facility, who shall ensure that:

23.7.1 Written policies and procedures for linen and laundry services, including methods of storage and transportation, are developed and implemented;

23.7.2 Soiled linen and laundry are collected so as to avoid microbial dissemination into the environment, and are placed in impervious bags or containers that are closed at the site of collection. Separate containers shall be used for transporting clean linen and laundry, and soiled linen and laundry;

23.7.3 Soiled linen and laundry are stored in a ventilated area separate from any other supplies, and are not stored, sorted, rinsed or laundered in patient rooms, bathrooms, areas of food preparation and/or storage, or areas in which clean material and equipment are stored; and

23.7.4 The linen supply retained in the facility, including at least sheets, pillow cases, drawsheets (or their alternative), towels and washcloths, is three times the census, so that at least one set of clean linens remains on the shelves for each patient.

23.8 Laundering facilities located in the facility shall be separate from the clean linen processing area, patient rooms, areas of food preparation and/or storage, and areas in which clean material and equipment are stored.

23.9 If a commercial linen and laundry service is used, it shall be required to maintain at least the standards outlined herein, and to ensure that clean linen is packaged and protected from contamination until received by the facility.

24.0 **Emergency Procedures (Including Equipment Breakdown, Disaster and Fire Plan)**

24.1 The facility shall have a written emergency plan which shall include plans and procedures to be followed in case of medical emergencies, equipment breakdown, fire, or other disaster. The plan shall be developed with the assistance of fire and safety experts from local municipalities.

24.2 Procedures for emergencies shall specify persons to be notified, locations of emergency equipment and alarm signals, evacuation routes, procedures for evacuating patients, frequency of fire drills, and tasks and responsibilities assigned to all personnel.

24.3 Simulated drills of all plans shall be conducted on each shift at least four times a year and a record written of each such drill, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The drills shall include at least these types of emergencies:

24.3.1 Medical emergency;

24.3.2 Equipment failure or power loss;

24.3.3 Fire; and

24.3.4 Other disaster (storm, flood, other natural disaster, bomb scare or military alert).

24.4 The facility shall test at least one manual pull alarm each week of the year, and maintain a written log showing test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition.

24.5 Fire extinguishers shall be examined annually and maintained in accordance with manufacturers' and NFPA requirements.

24.6 All plans shall be posted throughout the facility.

24.7 The facility shall provide emergency medical services 24 hours a day. To this end:

24.7.1 The facility shall maintain, as a minimum, the following emergency equipment in each nursing unit:

Oxygen
Splints
Intravenous pole
Scissors
Syringes
Multi-sized catheters
Ambu bag and mask
Extension cord
Suction equipment with catheter tip
Needles
Intravenous solution
Airway

24.7.2 The facility shall maintain at least one intravenous cutdown tray and cardiac arrest board; and

24.7.3 Location of emergency medications and equipment, such as EKG machine, oxygen, aspirator, smoke masks and other equipment, shall be marked, and personnel instructed as to their location and use.

25.0 **Construction**

25.1 Standards for new buildings, additions, alterations and renovations to existing building shall be in accordance with the Uniform Construction Code and the standards imposed by the United States Department of Health, Education and Welfare (HEW), the Department of Health, and the Department of Community Affairs, specifically the HEW Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities (HEW Publication No. HRA 74-4000). In order to avoid conflict, Sections 302 (except as it pertains to area limitations), 1202.8, 1216.0, Article 5 except Sections 513.0, 519.0, 520.0, 521.0 and Article 6 except Section 618.7 through 618.9.3 of the building sub-code of the New Jersey Uniform Code shall not govern with respect to health care facilities. The HEW HRA 74-4000 shall serve as the Uniform Code of the State in all matters regulated by the sections herein specified.*

*HEW Publication No. HRA 74-4000 may be obtained from the U.S. Government Printing Office, Washington, D.C., at a cost of $1.45.

26.0 **Additional Requirements**

26.1 Standards for existing buildings or major alterations constructed after September, 1974 to August 1, 1977, shall conform to the United States Public Health Service Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities (HRA 74-4000), and the New Jersey Supplementary Standards to these requirements, dated April 22, 1968, with the following change:

26.1.1 There shall be a minimum of one single-bedded room, equipped with private bath and toilet, for every thirty beds licensed in the facility. (Two single-bedded rooms would be required for 31 through 60 beds, etc.).

26.2 Standards for existing buildings or major alterations constructed before September, 1974, shall conform to the United States Public Health Service Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities (930-A-7) and the New Jersey Supplementary Standards to this regulation, dated April 22, 1968.

26.3 Fire protection measures for existing facilities shall comply with applicable sections of NFPA (National Fire Protection Association) Standard No 101, Life Safety Code, 1967 Edition, prior to June 1, 1976.*

26.4 Effective June 1, 1976, all new facilities or additions shall comply with NFPA Standard No. 101, Life Safety Code, 1973 Edition.*

26.5 An existing facility which undergoes major alterations shall have the option of complying with either NFPA Standard No. 101, Life Safety Code, 1967 Edition, or NFPA Standard No. 101, Life Safety Code, 1973 Edition. If the facility chooses the 1973 Edition, the entire facility must be in compliance with this standard.

*Both the 1967 and 1973 editions of the Life Safety Code may be obtained from the National Fire Protection Association, 470 Atlantic Avenue, Boston, Massachusetts, at a cost of $2.50.

27.0 Effective Date of Regulations

27.1 These regulations rescind all previous standards for nursing homes and for intermediate care facilities levels A and B, as well as "Standards for an Intermediate Care Facility and Multiple Occupancy in a Nursing and/or Residential Care Facility."

27.2 If a patient is transferred from one level of care to another level of care within the same facility, administrative forms and processes which are unrelated to the care of patients need not be duplicated. Such forms and processes include: 5.6.9, 6.6.12.3, 6.6.12.4, 6.6.12.4.1, 6.6.12.4.2, 7.5.1, 7.5.2, 7.5.3, 7.9.1, 16.4.1, 16.4.2, 17.3.3, 17.3.4, 17.3.17, and 20.3.1.

27.3 Facilities of 45 or fewer beds shall have until June 30, 1980, to comply with those standards for staffing in nursing, dietary and social work services that represent an addition to the requirements in the previous manuals (those in effect until July 1, 1978) for skilled nursing homes and intermediate care facilities. For such facilities of 45 or fewer beds, the previous manuals will continue to be the basis for licensure until June 30, 1980.

27.3.1 During the two-year period from July 1, 1978 - June 30, 1980, the Department will undertake a study to determine whether these exemptions shall be continued.

CHP-D1
April 73

CHAPTERS 136 & 138, LAWS OF NEW JERSEY 1971
HEALTH CARE FACILITIES PLANNING ACT

(Chapter 136)
(NJSA 26:2H-1 et seq.)
(Chapter 138)
(NJSA 26:2H-8)

Approved May 10, 1971

New Jersey State
Department of Health
John Fitch Plaza, P. O. Box 1540
Trenton, New Jersey 08625

An Act concerning the licensing and regulation of health care facilities, transferring certain powers and duties from the Department of Institutions and Agencies to the State Department of Health, and to amend "An act concerning hospital service corporations and regulating the establishment, maintenance and operation of hospital service plans, and supplementing Title 17 of the Revised Statutes by adding thereto a new chapter entitled 'Hospital Service Corporations,'" approved June 14, 1938 (P.L.1938, c. 366).

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. It is hereby declared to be the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health. In order to provide for the protection and promotion of the health of the inhabitants of the State, the State Department of Health, which has been designated as the sole agency in this State for comprehensive health planning under the "Comprehensive Health Planning and Public Health Services Amendments of 1966" (Federal Law 89-749), as amended and supplemented, shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning, hospital and related health care services, and all public and private institutions, whether State, county, municipal, incorporated or not incorporated, serving principally as boarding, nursing or maternity homes or other homes for the sheltered care of adult persons or as facilities for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity or physical condition, shall be subject to the provisions of this act.

2. The following words or phrases, as used in this act, shall have the following meanings, unless the context otherwise requires:

a. "Health care facility" means the facility or institution whether public or private, engaged principally in providing services for health maintenance organizations, diagnosis or treatment of human disease, pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, out-patient clinic, dispensary, home health care agency, boarding home or other home for the sheltered care of adult persons and bioanalytical laboratory or central services facility serving one or more such institutions but excluding institutions that provide healing solely by prayer.

b. "Health care service" means the preadmission, out-patient, in-patient and post-discharge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of health maintenance organizations, diagnosis or treatment of human disease, pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board, but excluding services provided by a physician in his private practice or by practitioners of healing solely by prayer.

c. "Construction" means the erection, building, or substantial acquisition, alteration, reconstruction, improvement, renovation, extension or modification of a health care facility, including its equipment, the inspection and supervision thereof; and the studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

d. "Board" means the Health Care Administration Board established pursuant to this act.

e. "Government agency" means a department, board, bureau, division office, agency, public benefit or other corporation, or any other unit, however described, of the State or political subdivision thereof.

f. "State Health Planning Council" means the existing State Health Planning Council formed under the provisions of Federal Law 89-749, as amended and supplemented.

g. "Comprehensive area-wide health planning agency" means an officially recognized health planning agency formed under the provisions of Federal Law 89-749, as amended and supplemented.

h. "Area planning council" means a voluntary, non-profit organization composed of persons representative of hospitals, nursing homes, and consumers of medical care

ervices, formed for the purpose of planning the health acilities in a definite geographical area which is recognized y the commissioner through referral of applications for ertificate of need as provided by this act.

i. "Department" means the State Department of lealth.

j. "Commissioner" means the State Commissioner of lealth.

3. The commissioner shall recognize the State Health 'lanning Council, the comprehensive area-wide health lanning agencies and area planning councils as the recommending agencies in carrying out the purpose of this act. 'he State Health Planning Council shall act as the coordinating agency for the comprehensive area-wide health lanning agencies and area planning councils in all matters, ncluding but not limited to, comprehensive studies of equirements in various areas of the State for health care acilities.

4. There shall be in the State Department of Health, a lealth Care Administration Board which shall consist of 3 members, 11 of whom shall be appointed by the Govertor with the advice and consent of the Senate, and repreentative of medical and health care facilities and services, abor, industry and the public at large, and two of whom hall be ex-officio members. The State Commissioner of lealth and the Commissioner of Insurance or their desigated representatives, shall be ex-officio voting members of he board and shall serve on the board during their respecive terms of office. Of the original members appointed to he board, four shall be appointed for terms of 3 years, four or terms of 2 years, and three for terms of 1 year. Folowing the expiration of the initial terms, members of the oard shall be appointed for terms of 4 years. Any vacancy ccurring in the membership of the board shall be filled in he same manner as the original appointment, but for the nexpired term only. The board shall meet at least quarerly and at such other times as its rules may prescribe or s in its judgment, may be necessary. The appointive memers of the board shall serve without compensation but hall be reimbursed for necessary expenses incurred in the erformance of their duties.

5. a. The commissioner, to effectuate the provisions nd purposes of this act, shall have the power to inquire nto health care services and the operation of health care acilities and to conduct periodic inspections of such facilies with respect to the fitness and adequacy of the premises, equipment, personnel, rules and bylaws and the dequacy of financial resources and sources of future evenues.

b. The commissioner, with the approval of the board, hall adopt and amend rules and regulations in accordance ith the Administrative Procedure Act P.L.1968,c.410 C.52:14B-1 et seq.) to effectuate the provisions and purposes of this act, including but not limited to: (1) the estabshment of requirements for a uniform State-wide system f reports and audit relating to the quality of health care rovided, health care facility utilization and costs; (2) cerfication by the department of schedules of rates, payents, reimbursement, grants and other charges for health are services as provided in section 18; and (3) standards nd procedures relating to the licensing of health care facilies and the institution of additional health care services.

c. The commissioner may enter into contracts with any government agency, institution of higher learning, voluntary nonprofit agency, or appropriate planning agency or council; and such entities are authorized to enter into contracts with the commissioner to effectuate the provisions and purposes of this act.

d. The commissioner may provide consultation and assistance to health care facilities in operational techniques, including but not limited to, planning, principles of management, and standards of health care services.

e. At the request of the commissioner, health care facilities shall furnish to the Department of Health such reports and information as it may require to effectuate the provisions and purposes of this act, excluding confidental communications from patients.

f. The commissioner may institute or cause to be instituted in a court of competent jurisdiction proceedings to compel compliance with the provisions of this act or the determinations, rules, regulations and orders of the commissioner.

6. The commissioner shall designate an appropriate organizational unit in the State Department of Health to carry out the provisions and purposes of this act, which shall be under the supervision of a person who shall be appointed by and receive the compensation fixed by the commissioner, subject to appropriations made therefor.

7. No health care facility shall be constructed or expanded, and no new health care services shall be instituted after the effective date of this act except upon application for and receipt of a certificate of need as provided by this act. No agency of the State or of any county or municipal government shall approve any grant of funds for, or issue any license to, a health care facility which is constructed or expanded, or which institutes a new health care service, in violation of the provisions of this act.

8. No certificate of need shall be issued unless the action proposed in the application for such certificate is necessary to provide required health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of adequate and effective health care services. In making such determinations there shall be taken into consideration (a) the availability of facilities or services which may serve as alternatives or substitutes, (b) the need for special equipment and services in the area, (c) the possible economies and improvement in services to be anticipated from the operation of joint central services, (d) the adequacy of financial resources and sources of present and future revenues, (e) the availability of sufficient manpower in the several professional disciplines, and (f) such other factors as may be established by regulation. The commissioner shall cause appropriate surveys and studies to be made concerning the need for health care facilities and keep current records and statistics thereon by designated areas or regions of the State.

9. Certificates of need shall be issued by the commissioner in accordance with the provisions of this act and based upon criteria and standards therefor promulgated by the commissioner. The commissioner shall establish minimum needs for health care facilities in each area or region, and any applicant requesting a certificate of need who

falls within such minimum needs, and who otherwise complies in all respects with this act and the criteria and standards established pursuant thereto shall be issued such certificate.

No such certificate shall be denied without the approval of the board and prior to the determination by the board, the applicant shall have been granted opportunity for hearing; and no decision shall be made contrary to the recommendations of the State Health Planning Council unless the council and the applicant shall have been granted opportunity for hearing. The department shall arrange within 60 days for fair hearings on all such cases and the commissioner or his designee shall furnish the board, the council and the applicant in writing his recommendations and reasons therefor. The board within 30 days shall make its determination.

10. Application for a certificate of need shall be made to the department, and shall be in such form and contain such information as the department may prescribe. The department shall charge a nonreturnable fee, not less than $20.00 and not more than $250.00 for the filing of an application for a certificate of need as it shall from time to time fix in rules or regulations. Upon receipt of an application, copies thereof shall be referred by the department to the appropriate planning agencies or councils for review.

These appropriate agencies and councils shall provide adequate mechanisms for full consideration of each application submitted to them and for developing recommendations thereon. Such recommendations, whether favorable or unfavorable, shall be forwarded to the commissioner within 60 days of the date of referral of the application. A copy of the recommendations made shall be forwarded to the applicant.

Recommendations concerning certificates of need shall be governed and based upon the principles and considerations set forth in section 8 hereof.

No member, officer or employee of any planning body shall be subject to civil action in any court as the result of any act done or failure to act, or of any statement made or opinion given, while discharging his duties under this act as such member, officer, or employee, provided he acted in good faith with reasonable care and upon proper cause.

11. A certificate of need shall be valid for 1 year from the date of issue, except that the commissioner may renew the certificate for further periods where the applicant has shown to the satisfaction of the commissioner by adequate proof that substantial progress towards completion of the project has been demonstrated.

12. a. No health care facility shall be operated unless it shall: (1) possess a valid license issued pursuant to this act, which license shall specify the kind or kinds of health care services the facility is authorized to provide; (2) establish and maintain a uniform system of cost accounting approved by the commissioner; (3) establish and maintain a uniform system of reports and audits meeting the requirements of the commissioner; and (4) prepare and review annually a long range plan for the provision of health care services, which plan shall be compatible with the State Health Plan established pursuant to the "Comprehensive Health Planning and Public Health Services Amendments of 1966" (Federal Law 89-749) as related to medical health services, health care services, and health manpower.

b. (1) Application for a license for a health care facility shall be made upon forms prescribed by the department. The department shall charge such nonrefundable fees, not less than $50.00 and not more than $250.00 for the filing of an application for a license and any renewal thereof, as it shall from time to time fix in rules or regulations. The application shall contain the name of the health care facility, the kind or kinds of health care service to be provided, the location and physical description of the institution, and such other information as the department may require. (2) A license shall be issued by the department upon its findings that the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards of health care service are fit and adequate and there is reasonable assurance the health care facility will be operated in the manner required by this act and rules and regulations thereunder.

c. A license issued before the effective date of this act to a health care facility for its operation, upon the first renewal date thereafter, may be extended for a 1 year period of time, provided the facility then meets the requirements for licensure at the time said license was issued and submits an acceptable plan to meet current requirements at the end of said period of time.

13. In addition to authority granted to the department by this act or any other law, the department after serving the licensee with specific charges in writing, may assess penalties and collect the same within the limitations imposed by this act, deny, place on probationary or provisional license, revoke or suspend any and all licenses granted under authority of this act to any person, firm, partnership, corporation or association violating or failing to comply with the provisions of this act, or the rules and regulations promulgated hereunder.

Notice of the assessment of penalties, revocation, suspension, the placing on probationary or provisional license or denial of a license together with a specification of charges shall be served on the applicant or licensee, personally or sent by certified mail to the address of record and the notice shall set forth the particular reasons for the assessment, denial, suspension, the placing on probationary or provisional license or revocation of the license. Such assessment, denial, suspension, the placing on probationary or provisional license, or revocation shall become effective 30 days after mailing, unless the applicant or licensee, within such 30-day period shall meet the requirements of the department or shall file with the department a written answer to the charges and give written notice to the department of its desire for a hearing in which case the assessment, denial, suspension, the placing on probationary or provisional license, or revocation may be held in abeyance until the hearing has been concluded and a final decision rendered.

The department shall afford the licensee an opportunity for a prompt hearing on the question of the assessment of penalties, the issuance, suspension or the placing on a probationary or provisional license, or revocation of the license. The procedure governing such hearings shall be in accordance with the rules and regulations of the

department. Either party may be represented by counsel of his own choosing, and shall have the right to subpoena witnesses and to compel their attendance on forms furnished by the department.

The commissioner shall arrange for prompt and fair hearings on all such cases, render written decisions stating conclusions and reasons therefor upon each matter so heard, and is empowered to enter orders of denial, suspension, placing on probationary or provisional license or revocation consistent with the circumstances in each case, and may assess penalties and collect the same within the limitations imposed by this act.

14. Any person, firm, partnership, corporation or association who shall operate or conduct a health care facility without first obtaining the license required by this act, or who shall operate such health care facility after revocation or suspension of license, shall be liable to a penalty of $50.00 for each day of operation in violation hereof for the first offense and for any subsequent offense shall be liable to a penalty of $100.00 for each day of operation in violation hereof. Any person, firm, partnership, corporation or association who shall be found guilty of violating any rule or regulation adopted in accordance with this act as the same pertains to the care of patients and neglects to rectify same within 7 days after receiving notice from the department of such violation or who neglects to commence, within 7 days, such repairs to his licensed establishment after receiving notice from the department that hazardous or unsafe condition exists in or upon the structure in which the licensed premises is maintained shall be subject to a penalty of not less than $10.00 or more than $100.00 for each day that he is in violation of such rule or regulation. If, within 1 year after such violation such person, firm, partnership, corporation or association is found guilty of the same violation such penalties as hereinbefore set forth shall be doubled, and if there be a third violation within such time, such penalties shall be tripled. In addition thereto the department may, in its discretion, suspend the license for such time as it may deem proper.

Any person, firm, partnership, corporation or association who shall, except in cases of an emergency, maintain more patients in his premises than he is licensed so to do, shall be subject to a penalty in an amount equal to the charge collected from such patient or patients plus $25.00 for each extra patient so maintained.

15. Whenever a boarding home for sheltered care, boarding house or rest home or facility or institution of like character, not licensed hereunder by public or private advertising or by other means holds out to the public that it is equipped to provide postoperative or convalescent care for persons mentally ill or mentally retarded or who are suffering or recovering from illness or injury, or who are chronically ill, or whenever there is reason to believe that any such facility or institution, not licensed hereunder, is violating any of the provisions of this act, then, and in such case, the department shall be permitted reasonable inspection of such premises for the purpose of ascertaining whether there is any violation of the provisions hereof. If any such boarding home for sheltered care boarding house, rest home or other facility or institution shall operate as a private mental hospital, convalescent home, private nursing home or private hospital in violation of the provisions of this act, then the same shall be liable to the penalties which are prescribed and capable of being assessed against health care facilities pursuant to this act.

Any person, firm, association, partnership or corporation, not licensed hereunder, but who holds out to the public by advertising or other means that the medical and nursing care contemplated by this act will be furnished to persons seeking admission as patients, shall cease and desist from such practice and shall be liable to a penalty of $100.00 for the first offense and $500.00 for each subsequent offense, such penalty to be recovered as provided for herein.

16. The penalties prescribed and authorized by this act shall be recovered in a summary civil proceeding, brought in the name of the State in the Superior Court, a County Court or a county district court pursuant to the Penalty Enforcement Law (N.J.S. 2A:58-1 et seq.).

The commissioner may, in his discretion and subject to rules and regulations, accept from any licensee an offer in compromise in such amount as may in his judgment be proper under the circumstances in lieu of any suspension of any license by the commissioner. Any sums of money so collected by the commissioner shall be paid forthwith into the State Treasury for the general purposes of the State. In no case shall the penalty be compromised for a sum less than $250.00 for the first offense and $500.00 for the second and each subsequent offense; provided, however, that any penalty of less than $250.00 or $500.00, as the case may be, may be compromised for a lesser sum.

The department may maintain an action in the name of the State to enjoin any person, firm, partnership, association or corporation from continuing to conduct, manage or operate a health care facility without a license, or after suspension or revocation of license, or in violation of rules and regulations promulgated hereunder.

17. All orders or determinations under this act shall be subject to review by a court of competent jurisdiction in accordance with the Rules of Court.

18. a. No government agency and no hospital service corporation organized under the laws of the State shall purchase, pay for or make reimbursement or grant-in-aid for any health care service provided by a health care facility unless at the time the service was provided, the health care facility possessed a valid license or was otherwise authorized to provide such service.

b. Payment by government agencies for health care services provided by a health care facility shall be at rates established by the commissioner, based on elements of costs approved by him.

c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care services, as reported by health care facilities, which are derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

d. Payment by hospital service corporations, organized under the laws of this State, for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the

approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility.

19. All of the functions, powers and duties of the State Board of Control, the Commissioner of Institutions and Agencies and the Department of Institutions and Agencies and its Hospital Licensing Board related to administration of laws governing and concerning boarding homes for the sheltered, care of children and adult persons, private mental hospitals, convalescent homes, private nursing homes and private hospitals, and relating to the planning, construction and licensing of health care facilities as defined in this act and the power to receive, allocate, expend, and authorize the expenditure of Federal moneys available for health care facility construction and renovation are hereby transferred and assigned to, assumed by and devolved upon the State Department of Health. To effectuate such transfer there shall also be transferred such officers and employees as are necessary, all appropriations or reappropriations, to the extent of remaining unexpended or unencumbered balances thereof, whether allocated or unallocated and whether obligated or unobligated, and all necessary books, papers, records and property. All rules, regulations, acts, determinations and decisions in force at the time of such transfer and proceedings or other such matters undertaken or commenced by or before the Department of Institutions and Agencies or the Hospital Licensing Board pertaining to the planning, construction, licensing and operation of such health care facilities, and the administration of Federal moneys for health care facility construction, and renovation pending at the time of such transfer, shall continue in force and effect until duly modified, abrogated or completed by the Department of Health.

20. Employees of the present Bureau of Community Institutions in the Department of Institutions and Agencies responsible for administration of laws governing and concerning boarding homes for the sheltered care of adult persons, private mental hospitals, convalescent homes, private nursing homes and private hospitals are hereby transferred to the State Department of Health. Persons so transferred shall be assigned such duties as the State Commissioner of Health shall determine.

21. All functions, powers, duties, records, and property of the Department of Institutions and Agencies, and personnel of the Bureau of Medical Facilities Construction and Planning relating to receipt of money from the Federal Government for the purpose of making payments for construction of hospitals, including public health centers and related facilities within the State, and for an inventory and survey in connection therewith under or pursuant to any Federal law providing for the payment of such moneys as established and authorized by the provisions of c.83, P.L. 1947 (C.30:1-19 et seq.), are hereby transferred to the State Department of Health.

22. The Hospital Licensing Board created pursuant to P.L. 1947, c.340, s.7 (c.30:11-6) is hereby abolished. Upon the establishment of the Health Care Administration Board, all the functions, powers and duties of the Hospital Licensing Board, transferred to and vested in the Department of Health pursuant to section 19 of this act, shall be assumed by and devolved upon the Department of Health, to be exercised by the said Health Care Administration Board. Pending the appointment of members, establishment and convening of said Health Care Administration Board, all the functions, powers and duties thereof shall be exercised by the department.

23. With respect to the functions, powers and duties of the State Board of Control, the Commissioner of Institutions and Agencies and the Department of Institutions and Agencies, which are herein transferred and vested in the Department of Health, whenever in any law, rule, regulation, contract, document or otherwise, reference is made to the State Board of Control or the Department of Institutions and Agencies the same shall be deemed to mean and refer to the Department of Health, and reference to the Commissioner of Institutions and Agencies in connection therewith shall be deemed to mean and refer to the Commissioner of Health.

24. If any clause, sentence, paragraph, subsection or section of this act shall be adjudged by any court of competent jurisdiction to be invalid, the judgment shall not affect, impair or invalidate the remainder thereof, but shall be confined in its operation to the clause, sentence, paragraph, subsection or section thereof directly involved in the controversy in which this judgment shall have been rendered.

25. Section 1 of c.366, P.L. 1938 (C.17:48-1) is amended to read as follows:

1. A hospital service corporation is hereby declared to be any corporation organized, without capital stock and not for profit, for the purpose of establishing, maintaining and operating a non-profit hospital service plan. A hospital service plan is hereby defined as a plan whereby health care services are provided by a hospital service corporation or by a health care facility with which the corporation has a contract for such health care services to persons who become subscribers under contracts with the corporation. Health care services provided by a hospital service corporation shall include health care provided (a) through a health care facility which is maintained by a State or any of its political subdivisions; (b) through a health care facility licensed by the Department of Health; (c) through such other health care facilities as shall have been designated by the Department of Health for health care services; (d) through health care facilities located in other states, which are subject to the supervision of such other States provided that such last mentioned health care facilities, if they were located in this State, would be eligible to be licensed or designated by the Department of Health; (e) through non-profit hospital service plans of other States approved by the Commissioner of Insurance.

26. Section 7 of c.366, P.L. 1938 (C.17:48-7) is amended to read as follows:

Rates of payment by such hospital service corporation pursuant to written contract with a hospital or institution for the services contracted thereunder may be in the form of a level per diem amount established for the particular hospital or institution for each day of health care services and prior to payment, shall be approved as to reasonable-

ness by the Commissioner of Insurance following certification made pursuant to section 18 of the Health Care Facilities Planning Act (P.L. 1971,c - 136). The maximum rate of payment to eligible hospitals and institutions not under contract with such hospital service corporation shall not exceed the particular hospital's or institution's regular charges to the general public for the same services and shall be set forth in the certificate issued by such hospital service corporation to any subscriber. The basis and extent of payment, if any, by such hospital service corporation under agreement with nonprofit hospital service plans of other states shall be subject to the approval of the Commissioner of Insurance.

27. Nothing in this act shall be construed to deprive any person of any tenure rights or of any right or protection provided him by Title 11 of the Revised Statutes, Civil Service, or under any pension law or retirement system.

28. This act shall be known and may be cited as the "Health Care Facilities Planning Act."

29. This act shall take effect at the beginning of t[illegible] eighth biweekly pay period following enactment except tha[illegible] all arrangements and actions necessary and appropriate to enable this act to become fully operative on such date shall be made as promptly as possible as though this act were effective and operative immediately.

Chapter 138

In the case of an application by a health care facility established or operated by any recognized religious body or denomination the needs of the members of such religious body or denomination for care and treatment in accordance with their religious or ethical convictions may be considered to be public need.

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.

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