CHAPTER 43F

STANDARDS FOR SERVICES AND LICENSURE OF ADULT AND PEDIATRIC DAY HEALTH SERVICES FACILITIES

Authority

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

Source and Effective Date

R.2001 d.205, effective June 18, 2001.
See: 32 N.J.R. 1920(a), 33 N.J.R. 2121(a).

Executive Order No. 66(1978) Expiration Date

Chapter 43F, Standards for Services and Licensure of Adult and Pediatric Day Health Services Facilities, expires on June 18, 2006.

Chapter Historical Note

Chapter 43F, Manual of Standards for Licensure of Non–Residential Medical Day Care Facilities, was adopted as R.1979 d.452, effective January 2, 1980. See: 11 N.J.R. 437(b), 11 N.J.R. 622(b).

Chapter 43F, Manual of Standards for Licensure of Non–Residential Medical Day Care Facilities, was repealed and Chapter 43F, Manual of Standards for Licensure of Adult Day Health Care Facilities, was adopted as new rules by R.1990 d.136, effective February 20, 1990. See: 21 N.J.R. 3385(a), 22 N.J.R. 635(a).

Subchapter 23, Physical Plant, and Subchapter 24, Functional Requirements, were adopted as R.1990 d.421, effective September 4, 1990. See: 21 N.J.R. 3403(a), 22 N.J.R. 2703(a).

Pursuant to Executive Order No. 66(1978), Chapter 43F, Manual of Standards for Licensure of Adult Day Health Care Facilities, was readopted as R.1995 d.128, effective February 7, 1995. See: 26 N.J.R. 4532(a), 27 N.J.R. 939(a). Pursuant to Executive Order No. 66(1978), Chapter 43F, Manual of Standards for Licensure of Adult Day Health Care Facilities, expired on February 7, 2000.

Chapter 43F, Standards for Services and Licensure of Adult and Pediatric Day Health Services Facilities, was adopted as new rules by R.2001 d.205, effective June 18, 2001. See: Source and Effective Date.

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SUBCHAPTER 1. GENERAL PROVISIONS

8:43F–1.1 Scope and purpose

The rules in this chapter pertain to all facilities that provide adult or pediatric day health services. These rules constitute the basis for the licensure and participation in the New Jersey Medicaid program of adult and pediatric day health service facilities by the New Jersey Department of Health and Senior Services. Adult and pediatric day health service facilities provide specialized, integrated care to participants in order to assist them in reaching the functional levels of which they are capable, as well as to protect their health and safety. The purpose of this chapter is to establish minimum rules to which an adult or pediatric day health service facility must adhere to be licensed to operate in New Jersey.

8:43F–1.2 Definitions

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

"Administration-adult day health services facility" means an identifiable administrative unit within the adult day health services facility headed by a director/administrator, responsible for the overall conduct of all adult day health service program activities.

"Activities of daily living (ADL)" means the functions or tasks for self-care, which are performed either independently or with supervision or assistance. Activities of daily living include at least mobility, transferring, walking, grooming, bathing, dressing and undressing, eating, and toileting. In pediatric day health care facilities, ADLs may include developmental stimulation, diaper changing and toilet training.

"Adult day health services beneficiary" means a person at least 18 years of age who is a Medicaid beneficiary, pursuant to N.J.A.C. 10:49–2.1, or a Home Care Expansion Program beneficiary, pursuant to N.J.A.C. 8:81, who is eligible for adult day health services pursuant to N.J.A.C. 8:43F–2.1.

"Adult day health services facility" means a facility or a distinct part of a facility which is licensed by the New Jersey Department of Health and Senior Services to provide preventive, diagnostic, therapeutic, and rehabilitative services under medical supervision to meet the needs of functionally impaired adult participants who are not related to the members of the governing authority by marriage, blood, or adoption. Adult day health services facilities provide services to participants for a period of time, which does not exceed 12 hours during any calendar day.

"Adult day health services participant" means a person who participates in a program of services from a licensed adult day health services facility.

"Adult Day Care Program for Victims of Alzheimer's Disease and Related Disorders" means a program administered by the Division of Senior Affairs, New Jersey Department of Health and Senior Services, which provides services to individuals who have a diagnosis by a physician as having Alzheimer's disease or a related disorder such as Huntington's disease, Parkinson's disease with dementia, Cruetzfeldt–Jacob disease, or Pick's disease.

"Ancillary nursing personnel" means unlicensed workers employed to assist licensed nursing personnel.

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

"Beneficiary or eligible beneficiary" means any person meeting the eligibility requirements of a recipient of benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:40–2 et seq.

"Bylaws" means 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 are acceptable as equivalents.

"Clinical note" means an event-triggered note, written, signed, and dated, when significant physical, emotional, mental, behavioral or social changes occur to the participant, when problems arise and/or services are provided on an intensive basis. The clinical note shall include a description of signs, symptoms, treatments, services and the participant's reactions. Clinical notes are written into the participant's medical record the day service is provided.

"Commissioner" means the New Jersey Commissioner of Health and Senior Services.

"Communicable disease" means an illness due to a specific infectious agent or its toxic products, which occurs through transmission of that agent or its products from a reservoir to a susceptible host.

"Conspicuously posted" means placed at a location within the facility accessible to and seen by participants and the public.

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

"Controlled Dangerous Substances Acts" means the Controlled Substances Act of 1970 (Title II, Public Law 91–513) and the New Jersey Controlled Dangerous Substances Act of 1970, N.J.S.A. 24:21–1 et seq.

"Daily census" means the number of participant equivalents who, during any calendar day, receive services in the facility. The number of participant equivalents is calculated by dividing the sum of all of the hours of services received by participants in the facility on a given day by the number five. For example, two participants each receiving 2.5 hours of service constitute one participant equivalent.

"Deficiency" means a determination by the New Jersey Department of Health and Senior Services that a facility is not in compliance with an applicable State licensing requirement and/or Federal requirement.

"Department" means the New Jersey Department of Health and Senior Services.

"Dietitian" means a person who is registered or eligible for registration by the Commission on Dietetic Registration (Office on Dietetic Credentialing, 216 W. Jackson Boulevard—7th Floor, Chicago, Illinois 60606–6995).

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

"Division" means the Division of Long Term Care Systems within the New Jersey Department of Health and Senior Services.

"Documented" means written, signed, and dated.

"Drug" means a substance as defined in the New Jersey State Board of Pharmacy rules, N.J.A.C. 13:39. The word "medication" is used interchangeably with the word "drug" in this chapter.

"Drug administration" means a procedure in which a prescribed drug is given to a participant by an authorized person in accordance with all laws and rules 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 prescriber's orders, giving the individual dose to the participant, seeing that the participant takes it (if oral), and recording the required information, including the method of administration.

"Epidemic" means the occurrence in a facility of one or more cases of an illness in excess of normal expectancy for that illness, derived from a common or propagated source.

"Family" means persons related by blood, marriage, or commitment.

"Full-time" means relating to a time period of not less than 35 hours, established by the facility as a full working week, as defined and specified in the facility's policies and procedures.

"HIV medical day care center (HIVMDC)" means a adult day health services facility which provides additional services to individuals with HIV infection in an identifiable and separate setting and which conforms to N.J.A.C. 8:43A.

"HIV medical day care participant" means a person at least 18 years of age with HIV infection who is eligible for adult day health services in accordance with N.J.A.C. 8:43F–2.1(d) and who requires out-patient drug abuse treatment.

"Health care facility" means a facility so defined in N.J.S.A. 26:2H–1 et seq.

"Interdisciplinary team" means those persons, representing different professions, disciplines, and services, who work together to provide an integrated program of care to the participant.

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

"Legally authorized representative" means spouse, immediate next of kin, legal guardian, participant's attorney, or third party insurer where permitted by law.

"License holder" means the person, or entity that has legal ownership and responsibility for all operations and management of the facility.

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

"Licensed practical nurse" (LPN) means a person who is so licensed by the New Jersey State Board of Nursing.

"Medical consultant" means a person who is licensed as a physician to practice medicine in the State of New Jersey. In a pediatric day health services facility, the medical consultant shall also be certified by the American Board of Pediatrics.

"Medical record" means all records in the facility pertaining to the participant, including radiological films.

"Medical record practitioner" means a person who is certified or eligible for certification as a registered record administrator (RRA) or an accredited record technician (ART) by the American Health Information Management Association (American Health Information Management Association, 919 N. Michigan Ave, Suite 1400 Chicago, Il 60611); or is a graduate of a program in medical record science accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the Council on Education of the American Health Information Management Association (American Health Information Management Association, 919 N. Michigan Ave, Suite 1400 Chicago, IL 60611).

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

"Nosocomial infection" means an infection acquired by a participant while in the facility.

"Nurse practitioner/clinical nurse specialist" means a person who is so certified by the New Jersey Board of Nursing, in accordance with N.J.A.C. 13:37–7.

"Occupational therapist" means a person who is so licensed, or eligible for licensure, by the New Jersey Occupational Therapy Advisory Council in accordance with N.J.S.A. 45:9–37.51.

"Pediatric day health services beneficiary" is a child from zero through five years of age who is a Medicaid beneficiary and who is technology dependent and/or medically unstable, as specified at N.J.A.C. 8:43F–2.1(e)1, and requires continuous nursing services available in a pediatric day health services facility.

"Pediatric day health services facility" means a facility which provides additional services in order to provide for the needs of technologically dependent or medically unstable children and conforms to this chapter and N.J.A.C. 10:122, the Manual of Requirements for Child Care Centers.

"Pediatric day health services participant" means a child who is six years of age or younger, who is technology dependent and/or medically unstable as defined in N.J.A.C. 8:43F–2.1(e) and requires continuous nursing services available in a pediatric day health services facility.

"Pharmacist" means a person who is so licensed by the New Jersey State Board of Pharmacy, pursuant to N.J.A.C. 13:39–3.

"Physical therapist" means a person who is so licensed by the New Jersey State Board of Physical Therapy Examiners.

"Physician" means a person who is licensed or authorized by the New Jersey State Board of Medical Examiners to practice medicine in the State of New Jersey.

"Physician assistant" means a person who holds a physician's assistant license in accordance with N.J.A.C. 13:35–2B.

"Prescriber" means a person who is authorized to write prescriptions in accordance with Federal and State laws.

"Prior authorization" means the approval process of eligible Medicaid participants by the Department prior to the provision of adult or pediatric day health services. In the context of day health services, prior authorization shall be used as outlined in N.J.A.C. 8:43F–1.7(e)1 or at the Department's discretion with new and existing day health services facilities.

"Progress note" means a written, signed, and dated notation summarizing information about care provided and the participant's response to it.

"Recipient" means a qualified applicant receiving benefits under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D–1 et seq.

"Registered professional nurse" (RN) means a person who is so licensed by the New Jersey State Board of Nursing.

"Respite" or "respite care" means the provision of temporary, short-term care for, or the supervision of, an eligible person on behalf of the caregiver in emergencies or on an intermittent basis to relieve the daily stress and demands of caring for a functionally impaired adult. Respite may be provided hourly, daily, overnight, or on weekends and may be provided by paid or volunteer staff. The term includes, but is not limited to, companion or sitter services, homemaker and personal care services, adult day health services, short-term inpatient care in a licensed nursing facility, residential health care facility or overnight camp program, private duty nursing and peer support and training for care givers.

"Restraint" means a physical device or chemical (drug) used to limit, restrict, or control participants' movements.

"Self administration" means a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a participant to himself or herself.

"Signature" means, at a minimum, the first initial and full surname and title (for example, R.N., L.P.N., D.D.S., M.D., D.O.) of a person, legibly written with his or her own hand. A controlled electronic signature system may be used.

"Social worker" means a person who is certified or licensed by the New Jersey State Board of Social Work Examiners.

"Speech-language pathologist" means a person who holds a current New Jersey license issued by the Audiology and Speech–Language Pathology Advisory Committee, Division of Consumer Affairs of the New Jersey Department of Law and Public Safety.

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

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

"Sterilization" means a process of destroying all microorganisms, including those bearing spores, in, on, and around an object.

"Supervision" means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his or her sphere of competence, with initial direction and periodic on-site inspection of the actual act of accomplishing the function or activity.

"Transportation services" means the conveying of participants who require transportation between the facility and the participant's home, either directly or through contractual arrangements. No participant's daily transportation time shall exceed two hours.

"Volunteer" means a person who gives his or her time and services regularly without remuneration.

8:43F–1.3 Licensure application procedures and requirements

(a) Any person, organization, or corporation desiring to operate an adult or pediatric day health services facility shall make application to the Commissioner for a license on forms prescribed by the Department. Such forms may be obtained from:

Director
Long Term Care Licensing and Certification
Division of Long Term Care Systems
New Jersey Department of Health and Senior Services
PO Box 367
Trenton, NJ 08625–0367

1. The Department shall charge a nonrefundable fee of $1,500 plus $10.00 per slot for the filing of an application for licensure and $1,500 plus $10.00 per slot for each annual renewal thereof.

2. The Department shall charge a nonrefundable fee of $1,500 plus $10.00 per additional slot to add services or program slots to an existing adult or pediatric day health services facility.

3. The Department shall charge a nonrefundable fee of $375.00 for the filing of an application to reduce services at an existing adult or pediatric day health services facility.

4. The Department shall charge a nonrefundable fee of $375.00 for the filing of an application for the relocation of an adult or pediatric day health services facility.

5. The Department shall charge a nonrefundable fee of $1,500 for the filing of an application for the transfer of ownership of an adult or pediatric day health services facility.

6. All applicants shall demonstrate that they have the capacity to operate an adult or pediatric day health services facility in accordance with the rules in this chapter. An application for a license or change in service shall be denied if the applicant cannot demonstrate that the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards of health care are fit and adequate and that there is reasonable assurance that the health care facility will be operated in accordance with the standards required by these rules. The Department shall consider an applicant's prior history in operating a health care facility either in New Jersey or in other states in making this determination. Any evidence of licensure violations representing serious risk of harm to participants may be considered by the Department, as well as any record of criminal convictions representing a risk of harm to the safety or welfare of participants.

7. Each adult and pediatric day services facility shall be assessed a biennial inspection fee of $450.00. This fee shall be assessed in the year the facility will be inspected, along with the annual licensure fee for that year. The fee shall be added to the initial licensure fee for new facilities. Failure to pay the inspection fee shall result in nonrenewal of the license for existing facilities and the refusal to issue an initial license for new facilities. This fee shall be imposed only every other year even if inspections occur more frequently and only for the inspection required to either issue an initial license or to renew an existing license. This fee shall not be imposed for any other type of inspection.

Amended by R.2004 d.160, effective April 19, 2004.
See: 35 N.J.R. 4838(), 36 N.J.R. 1962(a).
In (a), increased fees throughout.

8:43F–1.4 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of N.J.S.A. 26:2H-1 et seq. and the rules in this chapter, waive provisions of these rules if, in his or her opinion, such waiver

would not render the premises, equipment, personnel, finances, rules and bylaws, and standards of health care at a facility unfit or inadequate.

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

2. A written request for waiver shall include the following:

i. The specific rule(s) or part(s) of the rule(s) for which waiver is requested;

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

iii. An alternative proposal which would ensure the care and safety of participants; and

iv. Documentation to support the request for waiver.

3. The Department reserves the right to request additional information before processing a request for waiver.

8:43F–1.5 Newly constructed or expanded facilities

(a) The licensure application for a newly constructed, renovated or expanded facility shall include written approval of final construction of the physical plant by:

Health Care Plan Review Services
Division of Codes and Standards
New Jersey Department of Community Affairs
PO Box 815
Trenton, NJ 08625–0815
609–633–8151

1. Any existing or proposed adult or pediatric day health services facility with a construction program shall submit plans to the Health Care Plan Review Services, Division of Codes and Standards, Department of Community Affairs, PO Box 815, Trenton, NJ 08625–0815, for review and approval prior to the initiation of construction.

2. An on-site inspection of the construction of the physical plant shall be made by representatives of Health Care Plan Review Services to verify that the building has been constructed in accordance with the architectural plans approved by the Department of Community Affairs. At the discretion of the Health Care Plan Review Services a certificate of occupancy issued by the local municipality may be submitted in lieu of an on-site inspection.

8:43F–1.6 Preliminary conference

When a newly constructed facility is approximately 80 percent complete or when an applicant's estimated date of opening is within 30 days, the applicant shall schedule a preliminary conference with the Long Term Care Licensing and Certification Program for review of the conditions for licensure and operation.

8:43F–1.7 Surveys

(a) When the written application for licensure is approved and the building is ready for occupancy, a survey of the facility by representatives of the Department shall be conducted at the Department's discretion to determine if the facility adheres to the rules in this chapter.

1. The facility shall be notified in writing of the findings of the survey, including any deficiencies found.

2. The facility shall notify the Division of Long Term Care Systems of the Department when the deficiencies, if any, have been corrected, and the Assessment and Survey Program will schedule one or more resurveys of the facility prior to occupancy.

3. Professional personnel shall be employed in accordance with the staffing requirements in this chapter.

(b) No facility shall admit participants to the facility until the facility has the approval and/or license issued by the Long Term Care Licensing and Certification Program of the Department.

(c) Survey visits may be made to a facility at any time by authorized representatives of the Department. Such visits may include, but not be limited to, the review of all facility documents and participants' records and conferences with participants.

(d) The Department shall conduct an on-going evaluation of the day health services facility by on-site visits. A Day Health Services On–Site Report (chapter Appendix D, incorporated herein by reference) shall be completed by Department staff and a copy shall be forwarded to the facility.

(e) Department staff may request a plan of correction if the facility is evaluated as providing substandard services and/or inadequate documentation of these services. The plan of correction shall address deficiencies noted by the Department staff, and shall be submitted to the Department by the facility by the requested date.

1. If a follow-up on-site visit reveals the plan of correction is not being implemented, a ban on new admissions to the facility or other such actions as the Department deems necessary may be considered. For example, prior authorization of services may be imposed. Continued non-compliance with the Department's standards may result in the termination of the provider agreement, with a 30–day notice of termination sent to the facility by the Department. Providers wishing to request hearings under this section are referred to N.J.A.C. 10:49–10.3 and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

8:43F–1.8 License

(a) A license shall be issued if surveys by the Department have determined that the facility is operated as required by N.J.S.A. 26:2H-1 et seq. and the rules promulgated pursuant thereto.

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

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

(d) The license shall not be assignable or transferable and shall be immediately void if the facility ceases to operate, if the facility's ownership changes, or if the facility is relocated to a different site.

(e) The license, unless suspended or revoked, shall be renewed annually on or before its expiration date, or within 30 days thereafter but dated as of the original licensure date. The facility will receive a request for renewal fee 30 days prior to the expiration of the license. A renewal license shall not be issued unless the Department receives the licensure fee.

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

8:43F–1.9 Surrender of license

The facility shall notify each participant, the participant's physician, and any guarantors of payment 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 Long Term Care Licensing and Certification Program within seven working days after the voluntary surrender, revocation, non-renewal, or suspension of license.

8:43F–1.10 Action against a license

Pursuant to N.J.S.A. 26:2H–1 et seq., the Commissioner or his or her designee may impose all enforcement actions permitted under N.J.A.C. 8:43E for violations of licensure regulations or other statutory requirements. Enforcement actions include civil monetary penalty, curtailment of admissions, appointment of a receiver, provisional license, suspension or revocation of a license, order to cease and desist operation of an unlicensed health care facility, and other remedies for violations of statutes as provided by State or Federal law.

8:43F–1.11 Hearings

(a) If the Department proposes to suspend, revoke, deny, assess a monetary penalty, or refuse to renew a license, the licensee or applicant may request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq. and 52:14F–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

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

SUBCHAPTER 2. MEDICAID ELIGIBILITY AND PROGRAM PARTICIPATION FOR ADULT AND PEDIATRIC DAY HEALTH SERVICES

8:43F–2.1 Medicaid eligibility

(a) In order to be eligible for services through adult or pediatric day health services facilities, an individual must be eligible for one of the following: community Medicaid, New Jersey Care Special Medicaid program (including the medically needy segment), NJ KidCare–Plan A, fee-for-service, certain home care programs including Community Care Program for the Elderly and Disabled (CCPED), Alternate Family Care (AFC) program, Model Waivers, the AIDS Community Care Alternatives Program (ACCAP), the Traumatic Brain Injury Program, or the ABC Program for medically fragile children. Persons enrolled in the Home Care Expansion Program are likewise eligible for adult day health services.

(b) In order to be determined eligible for adult and pediatric day health services, a person shall, because of the severity, duration or frequency of need for service, require either:

1. Ongoing skilled services in the professional disciplines of nursing, physical therapy, occupational therapy, or speech therapy; or

2. Assistance in one or more activities of daily living (grooming, mobility, dressing, eating, toileting, bathing, transferring) and whose assessed physical and psychosocial needs:

i. Do not require services 24 hours a day on an inpatient basis in a hospital or nursing facility, except under special circumstances;

ii. Cannot be met totally in any other ambulatory care setting, such as a physician's office, hospital outpatient department or in a partial care/ partial hospitalization program;

iii. Require, and can be met satisfactorily by, a five-hour adult day health services program, exclusive of transportation time, not to exceed five days per week, or a minimum of six hours of pediatric day health services per day, exclusive of transportation; and

iv. Are such that current health status would deteriorate without the direct services and health monitoring available at the facility.

(c) Medicaid beneficiaries residing in a residential health care facility (RHCF) are ineligible for adult day health care services.

1. A written request for an exception may be made for the following reasons:

i. If a resident of an RHCF was receiving adult day health services prior to admission to the RHCF, the Department may approve adult day health services to

allow for the adjustment into the RHCF for up to 90 calendar days;

ii. If a resident of an RHCF requires adult day health services to encourage transition into a less structured residential setting, such as a boarding home or an independent living arrangement, the Department may approve adult day health services for a transitional period for up to 90 calendar days;

iii. If a resident of an RHCF has been recently discharged from an acute care facility (general hospital, psychiatric hospital) the Department may approve adult health care services for up to 90 calendar days; or

iv. If a resident of an RHCF has been diagnosed with a clinical condition which requires a short term structured therapeutic environment the Department may approve adult day health services for up to 90 calendar days.

2. The request should contain a justification for the reasons listed above, the specific time frame that adult day health services are needed, the signature of the attending physician and be sent to:

Director
Office of Waiver and Program Administration
Department of Health and Senior Services
PO Box 722
Trenton, NJ 08625–0722

(d) In order to be eligible for HIV adult day health services, a person shall be at least 18 years of age, eligible for adult day health services in accordance with (a) above, have a diagnosis of HIV, and require out-patient drug abuse treatment.

(e) In order to be eligible for pediatric day health services, a pediatric day health services beneficiary shall be from zero through five years of age and require continuous nursing services only available in a pediatric day health services facility serving technology dependent and medically unstable children.

1. A child served in a pediatric day health services facility shall meet either of the following criteria:

i. Be technology dependent, requiring life-sustaining equipment or interventions, including a tracheotomy, ventilator, central venous pressure (CVP) line, hyperalimentation gastrostomy tube or a nasogastric tube; or

ii. Be medically unstable requiring ongoing treatment administered by a licensed registered professional nurse (RN) or licensed practical nurse (LPN), such as nebulizer treatments, administration of oxygen, apnea/cardiac monitoring, intermittent urinary catheterization to maintain health or requiring ongoing monitoring and assessment by an RN because of such care needs as seizure disorders or cardiac conditions.

2. A child served in a pediatric day health services facility shall receive a minimum of six hours of services per day, exclusive of transportation time, not to exceed five days per week. In exceptional circumstances, if six hours is contraindicated because of the medical condition of the child the attending physician shall approve less than six hours but in no case less than three hours attendance and this shall be documented in the child's medical record and reviewed at least every 60 days.

8:43F–2.2 Medicaid program participation and prior authorization

(a) A day health services facility shall meet the following requirements in order to participate in the New Jersey Medicaid, NJ KidCare–Plan A, fee-for-service, and the Home Care Expansion Programs:

1. Licensure and approval by the Department of Health and Senior Services in accordance with the Manual of Standards for Licensure of Adult and Pediatric Day Health Services Facilities, as set forth in this chapter.

2. Completion of the New Jersey Medicaid Provider Application PE–1 (chapter Appendix A, incorporated herein by reference), the Participation Agreement PE–5 (chapter Appendix B, incorporated herein by reference), and a written narrative statement on the proposed adult or pediatric day health services facility (chapter Appendix C, incorporated herein by reference). On-going participation as a provider is contingent upon continued licensure by the Department; and

3. Completion, on a quarterly basis of a Day Health Services Participant Profile, (chapter Appendix E, incorporated herein by reference) on each participant who attends medical day care for five or more days during the quarter.

(b) The Department shall require that a new or existing adult or pediatric day health services facility be subject to prior authorization of eligible Medicaid beneficiaries prior to the provision of services at the discretion of the Department in accordance with the definition of "prior authorization" at N.J.A.C. 8:43F–1.2.

SUBCHAPTER 3. ADMINISTRATION AND ORGANIZATION

8:43F–3.1 Ownership

The license holder shall have responsibility for the management, operation, and financial viability of the facility.

8:43F–3.2 Disclosure of ownership

(a) The ownership of the management and operation of the facility and the ownership of the property on which it is located shall be disclosed to the Department. Proof of this ownership shall be available in the facility.

(b) No facility shall be owned or operated by any person convicted of a crime relating adversely to the person's capability of owning or operating the facility, including, but not limited to, continuing or serious violations of State licensure standards or Federal certification standards or by existence of a criminal conviction or a plea of guilty to a charge of fraud, participant abuse or neglect, or crime of violence or moral turpitude.

8:43F–3.3 Transfer of ownership

(a) Any proposed change in ownership shall be reported to the Director of the Long Term Care Licensing and Certification Program of the Department in writing at least 30 days prior to the change.

(b) Prior to transferring ownership of a facility, the prospective new owner shall submit an application to the Long Term Care Licensing and Certification Program. The application shall include the following information:

1. The cover letter stating the applicant's intent to purchase the facility, and identification of the facility by name, address, county, and licensed participant capacity;

2. A description of the proposed transaction, including identification of the current owners of the facility; identification of 100 percent of the proposed new owners, including the names and addresses of all principals (that is, individuals and/or entities with a 10 percent or more interest); and, if applicable, a copy of an organizational chart, including parent corporations and wholly owned subsidiaries;

3. A copy of the agreement of sale and, if applicable, a copy of any lease and/or management agreements; and

4. Disclosure of any licensed health care facilities owned, operated, or managed by the proposed owner or any of the principals, in New Jersey or any other state. If facilities are owned, operated, or managed in other states, letters from the state health departments or regulatory agencies in each respective state, verifying that the facilities have operated in substantial compliance during the last 12 month period and have had no enforcement actions imposed during that period of time, must be included in the application.

(c) The review of an application for a transfer of ownership shall include an evaluation of the applicant's track record, in accordance with N.J.A.C. 8:33–4.10 and 8:43E–5.1.

(d) When a transfer of ownership application has been reviewed and deemed acceptable, an approval letter from the Long Term Care Licensing and Certification Program shall be sent to the applicant along with licensure application forms.

(e) After the transaction has been completed, the applicant shall submit the following documents to the Long Term Care Licensing and Certification Program:

1. Completed licensure application forms and the annual licensure fee;

2. A notarized letter stating the date on which the transaction occurred; and

3. A copy of a certificate of continuing occupancy from the local township, or a letter from the township verifying a policy of not issuing any such document for changes of ownership.

(f) For Medicaid certification, the new owner shall contact the Long Term Care Licensing and Certification Program at (609) 633–9042.

8:43F–3.4 Appointment and responsibilities of the administrator

(a) The license holder shall appoint an administrator who is a full-time employee of the facility. The administrator, or an alternate who shall be designated in writing to act in the absence of the administrator, shall be available on the premises of the facility during the hours when participant care services are being provided.

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

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

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

3. Participating in the quality assurance program for participant care and staff performance;

4. Ensuring that all personnel are assigned duties based upon their education, training, competencies, and job descriptions;

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

6. Establishing and maintaining liaison relationships and communication between facility staff and services providers and with participants and their caregivers.

8:43F–3.5 Emergency plans and procedures

(a) The facility shall develop written emergency plans, policies, and procedures which shall include plans and procedures to be followed in case of medical emergency, equipment breakdown, fire, or other disaster.

(b) The facility shall maintain emergency equipment, including at a minimum, oxygen, suction, airway and ambubag.

1. At least one person who is currently certified in cardiac life support shall be immediately available on the premises of the adult day health care facility at all times.

(c) Procedures for emergencies shall specify persons to be notified, process of notification and verification of notification, locations of emergency equipment and alarm signals, evacuation routes, procedures for evacuating participants, procedures for reentry and recovery, frequency of fire drills, and tasks and responsibilities assigned to all personnel.

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

(e) In the event that the facility is unable to provide services to participants as scheduled due to the occurrence of an emergency, the facility shall immediately notify these participants of the change in schedule.

(f) Drills of emergency plans shall be conducted at least four times a year and documented, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The four drills shall include at least one drill for emergencies due to fire. The facility shall conduct at least one drill per year for emergencies due to another type of disaster, such as storm, flood, other natural disaster, bomb threat, or nuclear accident. All staff shall participate in at least one drill annually, and program participants may take part in drills.

(g) Fire extinguishers shall be examined annually and maintained in accordance with manufacturers' and National Fire Protection Association (NFPA) requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance.

8:43F–3.6 Administrative policies and procedures

(a) If a health care facility licensed by the Department provides adult day health services in addition to other health care services, the facility shall adhere to the rules in this chapter and to the rules for licensure of facilities providing the other health care services.

(b) Except in an emergency, facilities shall not provide program services to individual participants for more than 12 consecutive hours during any calendar day of the year without prior written approval by the Department.

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

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

1. A written statement of the program's philosophy and objectives and the services provided by the facility;

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

3. A description of mechanisms for referral of participants to other health care providers, in order to provide a continuum of care for the participant;

4. A description of the quality assurance program for participant care and staff performance;

5. Specification of the hours and days on which services are provided;

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

7. Policies and procedures, including content and frequency, for physical examinations upon employment and subsequently for employees and for other persons providing direct care services to participants; and

8. Policies and procedures for complying with applicable statutes and protocols to report abuse or mistreatment of elderly or disabled adults, child abuse, sexual abuse, specified communicable disease, rabies, poisonings, and unattended or suspicious deaths. These policies and procedures shall include, but not be limited to, the following:

i. The notification of any suspected case of participant abuse or exploitation to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly, pursuant to N.J.S.A. 52:27G–7.1 et seq., if the participant is 60 years of age or older, and if less than 60 years of age, to the DHSS Complaint Program, Division of Long Term Care Systems;

ii. The notification of any suspected case of child abuse or exploitation to the New Jersey Department of Human Services, Division of Youth and Family Services;

iii. The development of written protocols for the identification and the treatment of children, elderly or disabled adults who are abused and/or neglected; and

iv. The provision at least annually of education and/or training programs to appropriate persons regarding the identification and reporting of diagnosed and/or suspected cases of sexual abuse; domestic violence; abuse of the elderly or disabled adult; child abuse; and the facility's policies and procedures.

(e) The policy and procedure manual(s) shall be available and accessible to all participants, staff, and the public.

(f) The facility shall have a written agreement for services not provided directly by the facility. The written agreement, or its equivalent, shall specify that the facility retain administrative responsibility for services rendered and shall require that services be provided in accordance with the rules in this chapter.

(g) The facility shall notify the Department immediately by telephone at 609–633–9034 (609–392–2020 after business hours), followed within 72 hours by written confirmation, of the following:

1. Unanticipated interruption or cessation of program services for three hours or more (excluding closure for inclement weather);

2. Termination of employment of the administrator, and the name and qualifications of the administrator's replacement. If a new administrator cannot be designated within 72 hours, the Department shall be so notified in writing and the facility shall make arrangements for administrative supervision. A new administrator shall be appointed within 30 days;

3. Occurrence of epidemic disease in the facility;

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

5. All alleged or suspected crimes committed by or against participants, which shall also be reported at the time of occurrence to the local police department.

(h) The facility shall conspicuously post a notice that the following information is available in the facility to participants and the public:

1. All waivers granted by the Department in accordance with N.J.A.C. 8:43F–1.4(a);

2. The list of deficiencies from the last annual licensure inspection and certification survey report (if applicable), and the list of deficiencies from any valid complaint investigation during the past 12 months;

3. Policies and procedures regarding participant rights; and

4. A means of contacting the license holder.

8:43F–3.7 Financial arrangements

(a) The facility shall:

1. Inform participants in writing of the fees for services and supplies (where a fee is charged);

2. Maintain a written record of all financial arrangements with the participant and/or the participant's family, with copies furnished to the participant;

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

i. Upon written approval and authority of the participant and/or the participant's family, each of whom shall be given a copy of the written approval;

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

iii. Upon 15 days' prior written notice to the participant and/or the participant's family of additional charges, expenses, or other financial liabilities due to the increased cost of maintenance and/or operation of the facility; or

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

4. Describe for the participant agreements with third-party payors and/or other payors and referral systems for participant's financial assistance; and

5. Describe sliding fee scales and any special payment plans established by the facility.

8:43F–3.8 Quality assurance program

(a) The facility shall establish and implement a written plan for a quality assurance program for participant care. The plan shall specify a timetable and the person(s) responsible for the quality assurance program and shall provide for ongoing monitoring of staff and participant care services.

(b) Quality assurance activities shall include, but not be limited to, the following:

1. At least annual review of staff qualifications and credentials;

2. At least annual review of staff orientation and staff education;

3. Evaluation of participant care services, staffing, infection prevention and control, housekeeping, sanitation, safety, maintenance of physical plant and equipment, participant care statistics, and discharge planning services;

4. Evaluation by participants and their families of care and services provided by the facility;

5. Review of medication errors and adverse drug reactions by the consultant pharmacist;

6. Audit of participant medical records (including those of both active and discharged participants) on an ongoing basis to determine if care provided conforms to criteria established by each participant care service for the maintenance of quality of care; and

7. Establishment of objective criteria for evaluation of the participant care provided by each service.

(c) The results of the quality assurance program shall be submitted to the license holder at least annually and shall include, at a minimum, the deficiencies found and recommendations for corrections or improvements. Deficiencies that jeopardize participant safety shall be reported to the license holder immediately. The administrator shall implement measures to ensure that corrections or improvements are made.

8:43F–3.9 Participant care policies and procedures

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

1. Participant rights;

2. The determination of staffing levels on the basis of the daily census and on the basis of an assessment of the acuity of participant need;

3. The referral of participants to other health care providers, in order to provide a continuum of care for the participant;

4. Emergency care of participants, including notification of the participant's family;

5. Participant instruction and health education, including the provision of printed and/or written instructions and information for participants, with multilingual instructions as indicated;

6. Advance directives, including, but not limited to, the following:

i. The circumstances under which an inquiry will be made of adult participants;

ii. Requirements for provision of a written statement of participants' rights regarding advance directives, approved by the Commissioner or his or her designee, to such participants; and

iii. Requirements for documentation in the medical record;

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

i. At the facility's option, a smoke-free policy may be developed, which includes adequate notice to all applicants for admission to the facility;

ii. In the event that participants, staff and visitors are permitted to smoke, they shall smoke only in designated smoking areas having adequate outside ventilation;

iii. Nonflammable ashtrays in sufficient numbers shall be provided in designated smoking areas;

iv. Any room designated for smoking shall have acceptable indoor air quality and be equipped with a ventilation system that prevents contaminated air from recirculating through the facility;

8. Discharge, transfer, and readmission of participants, including criteria for each;

9. The care and control of pets if the facility permits pets in the facility or on its premises; and

10. Exclusion of participants from the facility, and authorization to return to the facility, for participants with communicable disease.

(b) Prior to admission of the participant, a member of the interdisciplinary team or a representative of a community health agency shall visit the participant's home and perform an assessment of the participant's home environment. The assessment shall be documented in the participant's medical record and shall include assessment of at least the following:

1. Living arrangements;

2. The participant's relationship with his or her family;

3. Amenities and facilities available, such as heat, toilet and bathing facilities, and provisions for preparing and storing food;

4. Existence of environmental barriers, such as stairs, not negotiable by the participant; and

5. Access to transportation, shopping, religious, social, or other resources to meet the needs of the participant.

(c) The administrator or a designee shall conduct an interview with the participant and, if possible, the participant's family prior to or at the time of the participant's admission. The interview shall include at least orientation of the participant to the facility's policies and services, hours and days on which services are provided, fee schedule, participant rights, and criteria for admission, treatment, and discharge. A summary of the interview shall be documented in the participant's medical record.

(d) A participant who manifests such a degree of behavioral disorder to allow the facility to reasonably believe that he or she is a danger to himself or herself or others, or whose behavior may interfere with the health or safety or well-being of other participants, shall not be admitted or retained.

(e) A person suffering exclusively from substance abuse or misuse shall not be admitted to or retained in the facility.

(f) All participants in adult day health services facilities shall be 16 years of age or older.

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

1. The participant shall be restricted to floors that are at grade level, or if not at grade level, the floor shall have handicap access to grade level;

2. Corridors on floors accommodating participants who require wheelchairs shall be at least 44 inches wide;

3. Each door through which the participant must travel to exit shall be at least 32 inches in clear width measured with the door open 90 degrees; and

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

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

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

(j) If an applicant, after applying in writing, is denied admission to the facility, the applicant and/or the applicant's family shall be given the reason for such denial in writing, signed by the administrator, within 15 days of receipt of the written application.

(k) Written notification by the administrator shall be provided to a participant and, if possible and appropriate, the family, of a decision to involuntarily discharge the participant from the facility. The notice shall include the reason for discharge and the participant's right to appeal. A copy of the notice shall be entered in the participant's medical record.

(*l*) The participant shall have the right to appeal to the administrator any involuntary discharge from the facility. The appeal shall be in writing, and a copy shall be included in the participant's medical record with the disposition or resolution of the appeal.

8:43F–3.10 Verbal and telephone orders

Verbal or telephone orders shall be written into the participant's medical record by the person accepting them and countersigned by the prescriber or verified via the original written order or a plain-paper faxed copy within seven days. Any limits on the use of verbal and telephone orders and criteria for their acceptance shall be defined in the facility's policies and procedures.

8:43F–3.11 Interpretation services

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

8:43F–3.12 Notification of family

The participant's family shall be notified in the event that the participant sustains an injury, or an accident or incident occurs, immediately after the occurrence. Immediately following such notification, the notification shall be documented in the participant's medical record.

8:43F–3.13 Use of restraints

The facility shall develop and provide individualized non-restrictive equipment meeting individual needs which fosters and supports a restraint-free environment for all adult participants. However, in pediatric day health facilities, pediatric safety guards may be used, in accordance with assessments and care plans.

8:43F–3.14 Participant follow-up

The facility shall establish and implement policies and procedures for follow-up of participants in the event that a participant does not appear for services on scheduled days, and for documentation of the follow-up in the participant's medical record.

8:43F–3.15 Provision of beds, lounges or recliners

The facility shall provide at least one item of comfortable furniture, such as a bed, lounge, recliner, or equivalent, selected in accordance with assessments of participants' needs to rest or recline, for every ten adult day health care participant equivalents, calculated on the basis of the licensed capacity.

8:43F–3.16 Assistance with activities of daily living

Assistance with activities of daily living shall be provided to participants who require such assistance.

8:43F–3.17 Security and accountability during transportation

The facility shall develop and implement plans for security and accountability for the participant and the participant's personal possessions while transportation services are being provided.

8:43F–3.18 Calibration of instruments

All instruments of measurement shall be calibrated in accordance with manufacturers' instructions.

8:43F–3.19 General record policies

(a) The following records shall be maintained by the facility:

1. A chronological listing of participants admitted and discharged, including the destination of participants who are discharged; and

2. Statistical data concerning utilization of program services and demographic information related to participants or other data as may be required by these rules.

8:43F–3.20 Maintenance of medical records

(a) A current, complete medical record shall be maintained for each participant and shall contain documentation of all services provided.

(b) Written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for medical record services shall be developed and implemented.

(c) A record system shall be maintained in which the participant's complete medical record is filed as one unit in one location within the facility.

8:43F–3.21 Assignment of responsibility

Responsibility for the medical record service shall be assigned to a full-time employee who, if not a medical record practitioner, functions in consultation with a person so qualified.

8:43F–3.22 Contents of medical records

(a) The participant's complete medical record shall include, but not be limited to, the following:

1. Participant identification data, including name, date of admission, address, date of birth, race, religion (optional), sex, referral source, payment plan, marital status, and the name, address, and telephone number of the person(s) to be notified in an emergency, and travel directions to the participant's home;

2. The participant's signed acknowledgment that the participant or the participant's legally authorized representative has been informed of, and given a copy of, participant's rights;

3. An assessment of the participant's home environment based upon a visit to the participant's home;

4. A summary of the admission interview;

5. Documentation of the medical history and physical examination signed and dated by the physician;

6. Assessments developed by each service providing care to the participant;

7. A care plan;

8. Clinical notes, which shall be entered on the day service is rendered;

9. Progress notes;

10. A record of medications administered, including the name and strength of the drug, date and time of administration, dosage administered, method of administration, and signature of the person who administered the drug;

11. A record of self-administered medications, if the participant self-administers medications;

12. Documentation of allergies in the medical record and on its outside front cover;

13. Documentation of dental, laboratory, and radiological services provided;

14. A record of referrals to other health care providers;

15. Documentation of consultations;

16. Any signed written informed consent forms;

17. Documentation regarding an advance directive, if applicable;

18. A record of any treatment, drug, or service offered by personnel of the facility and refused by the participant;

19. All orders for treatment, medication, and diets, signed by a physician. Physician orders for speech-language pathology, physical therapy, and occupational therapy services shall include specific modalities and the frequency of treatment;

20. An attendance record listing all of the days on which the participant was in the facility;

21. A current photograph of the participant; and

22. The discharge summary, in accordance with N.J.S.A. 26:8–5 et seq.

8:43F–3.23 Medical records policies and procedures

(a) All orders for participant care shall be prescribed in writing and signed and dated by the prescriber.

(b) All entries in the participant's medical record shall be written legibly in ink, dated, and signed by the recording person or, if a computerized medical records system is used, authenticated.

1. If an identifier such as a master sign-in sheet is used, initials may be used for signing documentation, in accordance with applicable professional standards of practice.

2. If computer-generated orders with an electronic signature are used, the facility shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of computer-generated signatures.

3. If a facsimile communications system (FAX) is used, entries into the medical record shall be in accordance with the following procedures:

i. The physician, nurse practitioner, certified nurse specialist, or New Jersey licensed physician assistant shall sign the order, history and/or examination at an off-site location;

ii. The order or document shall be faxed to the facility for inclusion into the medical record;

iii. The physician shall submit the original for inclusion into the medical record within seven days; and

iv. The faxed copy shall be replaced by the original. If the facsimile reports are produced by a plain-paper facsimile process that produces a permanent copy, the plain-paper report may be included as a part of the medical records, as an alternative to replacement of the copy by the original report.

(c) If a participant or the participant's legally authorized representative requests in writing a copy of his or her medical record, a legible photocopy of the record shall be furnished at a fee based on actual costs, which shall not exceed prevailing community rates for photocopying. A copy of the medical record shall be provided to the participant or the participant's legally authorized representative within 30 days of request.

1. The facility shall establish a policy assuring access to copies of medical records for participants who do not have the ability to pay.

2. The facility shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The participant or his or her authorized representative, however, has a right to receive a full or certified copy of the medical record.

(d) Access to the medical record shall be limited only to the extent necessary to protect the participant. A verbal explanation for any denial of access shall be given to the participant or legally authorized representative by the physician and there shall be documentation of this in the medical record. In the event that direct access to a copy by the participant is medically contraindicated (as documented by a physician in the participant's medical record), the medical record shall be made available to a legally authorized representative of the participant or the participant's physician.

(e) The participant shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.

(f) The record shall be protected against loss, destruction, or unauthorized use. Medical records shall be retained for a period of 10 years following the most recent discharge of the participant. A summary sheet shall be retained for a period of 20 years, and X-ray films or reproductions thereof shall be retained for a period of five years, in accordance with N.J.S.A. 26:8–5.

(g) The facility shall develop policies regarding the specific period of time within which the medical record shall be completed following participant discharge and disciplinary action for noncompliance.

(h) The facility shall develop a procedure for the transfer of participant information when the participant is transferred to another health care facility.

(i) If the facility plans to cease operation, it shall notify the Department in writing, at least 14 days before cessation of operation, of the location where medical records will be stored and of methods for their retrieval.

SUBCHAPTER 4. ASSESSMENT; PLAN OF CARE; PARTICIPANT'S RIGHTS

8:43F–4.1 Assessment

(a) A registered professional nurse (RN) shall assess the nursing needs of each participant, coordinate the written interdisciplinary care plan, and ensure the timeliness of all services.

(b) An initial assessment shall be completed for each participant on the day of admission and shall include at least personal hygiene, immediate dietary needs, medications, ambulation and diagnosis.

(c) A physician shall provide orders for each participant's care beginning on the day of admission.

(d) Each physician order shall be executed by the nursing, dietary, social work, activities, rehabilitation or pharmacy service, as appropriate in accordance with professional standards of practice.

(e) A comprehensive assessment shall be completed for each participant within 14 days of attendance. The comprehensive assessment shall include, at a minimum, evaluation of the following:

1. Cognitive patterns;
2. Communication/hearing patterns and vision;
3. Physical functioning;
4. Psychosocial well-being;
5. Medical condition/diagnoses:
6. Nutritional status and life style;
7. Oral/dental status;
8. Skin condition;
9. Medication use; and

10. Special treatment and procedures, assistive devices.

(f) The assessment required by (e) above shall be documented on the NJEASE Comprehensive Assessment Tool, incorporated herein by reference as chapter Appendix F, or on an equivalent assessment instrument which has been developed by the facility.

8:43F–4.2 Development and implementation of care plans, and discharge

(a) A written initial plan of care shall be developed, based on the initial assessment. The plan of care shall include, but not be limited to, the following:

1. Orders for treatment or services, medications, and diet, if needed;

2. The participant's needs and preferences for himself or herself;

3. The specific goals of care, if appropriate;

4. The participant's scheduled days of attendance; and

5. The time intervals at which the participant's response to treatment will be reviewed.

(b) The interdisciplinary care plan shall be based on the comprehensive assessments provided by nursing, dietary, activities, and social work staff; and when ordered by the physician, other health professionals, including pharmacy consultation, shall also provide assessments. The care plan shall include measurable objectives with interventions based on the participant's care needs and means of achieving each goal. The complete care plan shall include, if appropriate, rehabilitative/restorative measures, preventive intervention, and training and teaching of self-care.

(c) There shall be a scheduled review and evaluation in each service involved in the initial assessment, plus other areas which the physician or interdisciplinary team indicates are necessary. Reassessments shall be performed as necessary, based on participant's needs, but at least quarterly for adult participants.

(d) Care plans shall include discharge planning which will address the participant's changing status that may alter the appropriateness of day care and necessitate helping the caregiver to access alternative resources.

(e) The participant and, if indicated, family members shall assist in developing the plans for discharge.

8:43F–4.3 Policies and procedures regarding participant rights

(a) The facility shall establish and implement written policies and procedures regarding the rights of participants. These policies and procedures shall be available to participants, staff, and the public and shall be conspicuously posted in the facility.

(b) The staff of the facility shall receive in-service education concerning the implementation of policies and procedures regarding participant rights.

(c) The facility shall comply with all applicable State and Federal statutes and rules concerning participant rights, including N.J.S.A. 52:27G–7.1 et seq. The State of New Jersey Office of the Ombudsman for the Institutionalized Elderly shall be notified of any suspected case of participant abuse or exploitation pursuant to N.J.S.A. 52:27G–7.1 et seq., if the participant is 60 years of age or older. For participants under 60 years of age, the Department of Health and Senior Services shall be notified.

(d) The Department of Human Services, Division of Youth and Family Services, shall be notified of any suspected child abuse.

8:43F–4.4 Rights of each participant

(a) Participant rights, policies, and procedures shall ensure that, at a minimum, each participant admitted to the facility:

1. Is informed of these rights, as evidenced by the participant's (or, if the participant is incapacitated or under age 18, his or her parent's, legal guardian's, spouse's, or other responsible party's) written acknowledgement prior to or upon admission, and receives an explanation, in terms that the participant can understand, and a copy of the participant rights;

2. Is informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the participant's care, and is given a written statement of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;

3. Is assured of care in accordance with the care plan, and is informed of the care plan, unless medically contraindicated as documented by a physician in the participant's medical record. Upon request, is informed of the risks associated with the use of any drugs and/or procedures provided by the facility. Has the opportunity to participate in the planning of the participant's care. May give consent to or refuse medication and treatment, and may refuse to participate in experimental research;

4. Is informed of the alternatives for care and treatment;

5. Is transferred or discharged only for medical reasons or for the participant's welfare or that of other participants upon the written order of the participant's physician, as documented in the participant's medical record, except in an emergency situation, in which case the administrator shall notify the physician and the family immediately following the transfer and document the reason for the transfer in the participant's medical record. If a transfer or discharge on a non-emergency basis is requested by the facility, including transfer or discharge for nonpayment for services (except as prohibited by sources of third-party payment), the participant's and the participant's family shall be given at least 30 days advance written notice of such transfer or discharge;

6. Has access to and/or may obtain a copy of the participant's medical record, in accordance with the facility's policies and procedures;

7. Is free from mental and physical abuse, free from exploitation, and free from the use of chemical and physical restraints. Drugs and other medications shall not be used for punishment or for convenience of facility personnel;

8. Is assured confidential treatment of the participant's records and disclosures, and shall have the opportunity to approve or refuse their release to any individual, except in the case of the participant's transfer to another health care facility or as required by law or third-party payment contract;

9. Is treated with courtesy, consideration, respect, and recognition of the participant's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy and confidentiality concerning treatment and disclosures. Privacy of the participant's body shall be maintained during toileting, bathing, and other activities of personal hygiene;

10. Is not required to perform work for the facility unless the work is part of the care plan and is performed voluntarily by the participant. Such work shall be in accordance with local, State, and Federal laws and rules;

11. May associate and communicate privately with persons of the participant's choice and may join with other participant's or individuals within or outside the facility to work for improvements in participant care;

12. Is allowed to conduct private telephone conversations;

13. Is assured of 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 participant;

14. Is not the object of discrimination with respect to participation in regularly scheduled recreational activities (except as provided at N.J.A.C. 8:43F–5.21(c)), meals, or other social functions because of age, race, religion, sex, nationality, or ability to pay. The participant's participation may not be restricted or prohibited, unless the participant consents and the restriction or prohibition is documented by the participant's physician in the participant's medical record;

15. Is not deprived of any constitutional, civil, and/or legal rights solely because of admission to the facility; and

16. Is encouraged and assisted to exercise rights as a participant and as a citizen, may voice grievances on behalf of the participant or others, and has the right to recommend changes in policies and services to facility personnel and/or to outside representatives of the participant's choice, free from restraint, interference, coercion, discrimination, or reprisal.

(b) The administrator shall provide all participants and/or their families with the name, address, and telephone number of the following offices where complaints may be lodged:

Division of Long Term Care Systems
New Jersey Department of Health and Senior Services
PO Box 367
Trenton, New Jersey 08625–0367
Telephone: (800) 792–9770

State of New Jersey
Office of the Ombudsman for Institutionalized Elderly
PO Box 808
Trenton, New Jersey 08625–0808
Telephone: 1–877–582–6995

New Jersey Division of Medical Assistance and Health Services
PO Box 712
Trenton, N.J. 08625–0712
Telephone: (609)588–2630

Division of Youth and Family Services
PO Box 717
Trenton, N.J. 08625–0717
Telephone: (609) 292–6920, or (800)–792–8610

(c) The administrator shall also provide all participants and/or their families with the telephone number of the local (county) agency of the Adult Protective Services Program (APS), for adult participants, or the Division of Youth and Family Services Office of Child Abuse Control or District Office, for pediatric participants.

(d) The telephone numbers in (b) and (c) above, shall be conspicuously posted in the facility at every public telephone and on all bulletin boards used for posting public notices.

SUBCHAPTER 5. SERVICES

8:43F–5.1 General services provided

(a) The facility shall provide, in accordance with this chapter, preventive, diagnostic, therapeutic, and rehabilitative services to participants who do not require 24–hour inpatient health care.

(b) The facility, at a minimum, shall provide the following services: dietary, nursing, activities, pharmaceutical, and social work, directly in the facility.

(c) The facility shall provide or arrange for the following services: occupational therapy, physical therapy, and speech-language pathology, either in the facility or outside of the facility. Habilitative services shall be provided or arranged for children and adult participants with developmental disabilities.

(d) The facility shall make referrals for services, which shall include, but not be limited to, dental, laboratory, medical, and radiological.

(e) The facility shall provide transportation services, either directly or through contractual arrangements, to all participants who require transportation between the facility and the participant's home. No participant's transportation time shall exceed two hours to and from the facility.

(f) The adult day health service program shall be provided for at least five consecutive hours and no more than 12 hours daily, exclusive of transportation time, for a minimum of five days per week.

(g) Adult day health service facilities shall provide at least one full-time, or full-time equivalent, direct care staff member for every nine participant equivalents, calculated on the basis of the daily census.

(h) The facility shall maintain a daily record of participant attendance for each day during which services are provided.

8:43F–5.2 Dietary services

The adult day health care services facility shall provide a minimum of one meal per day to participants as well as nutritionally appropriate snacks. The meal shall supply at least one-third of the daily caloric and protein requirements recommended by the Nutrition Board of the National Academy of Sciences, National Research Council, and shall contain three or more menu items, one of which is or includes a high quality protein food such as meat, fish, eggs, or cheese.

8:43F–5.3 Administrator's responsibilities for dietary services

(a) If meals are prepared in the facility, the administrator shall designate a food service supervisor who, if not a dietitian, functions with scheduled consultation from a dietitian. The food service supervisor shall be present in the facility during food preparation and service.

(b) If the food service supervisor is not a dietitian, the administrator shall designate a consultant dietitian who shall review the dietary services on a regularly scheduled basis, make recommendations, assess the nutritional needs of participants and provide nutritional counseling.

(c) If meals are prepared off-site or catered, the administrator or the administrator's designee shall be responsible for the direction, provision and quality of the dietary services.

1. If the off-site catering service does not employ a food service supervisor who is qualified in accordance with N.J.A.C. 8:43F–6.5, the administrator or administrator's designee shall specify the facility's needs, assess the quality of the services, and ensure that the services conform to the standards of this chapter.

2. The administrator or the administrator's designee shall appoint a consultant dietitian who shall review the dietary services on a regularly scheduled basis, make recommendations, assess the nutritional needs of participants and provide nutritional counseling.

8:43F–5.4 Requirements for dietary services

(a) The dietary service shall comply with the provisions of N.J.A.C. 8:24.

(b) A current diet manual shall be available to personnel in the facility, and, if applicable, to the off-site food provider.

(c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following:

1. Menus shall be prepared with regard for the nutritional and therapeutic needs, cultural backgrounds, food habits, and personal food preferences of participants;

2. Written, dated menus shall be planned at least 14 days in advance for all diets. The same menu shall not be used more than once in any continuous seven-day period;

3. Current menus with portion sizes and any changes in menus shall be posted in the food preparation and/or serving area. Menus, with changes, shall be kept on file in the dietary service for at least 30 days;

4. Diets served shall be consistent with the diet manual and shall be served in accordance with physicians' orders;

5. Food shall be prepared by cutting, chopping, grinding, or blending to meet the needs of each participant;

6. Nutrients and calories shall be provided for each participant, 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 participant;

7. Nutritionally appropriate snacks shall be provided and beverages shall be available at all times for each participant, unless medically contraindicated as documented by a physician in the participant's medical record;

8. Substitute foods and beverages of equivalent nutritional value shall be available to all participants;

i. If food is prepared off-site, the facility shall have a system to inform the caterer each day of the number and types of meals required and any substitutions;

ii. Minimum supplies of food (for example, cereal, peanut butter, tuna, canned fruits and vegetables, and juices) shall be maintained in facilities with an off-site food preparation system so that simple meals can be prepared in the event there are last minute requests or emergency situations;

9. Designated staff shall be responsible for observing meals refused or missed and documenting the name of the participant and the meal refused or missed;

10. Self-help feeding devices shall be provided;

11. All meals shall be attractive when served to participants;

12. All participants shall eat in a dining area with sufficient space to accommodate all participants simultaneously at each meal; and

13. A record shall be maintained in the serving area for each participant, identifying the participant by name, diet order, and other information, such as meal patterns when on a calculated diet and allergies.

8:43F–5.5 Provision of medical services

(a) Medical services shall be provided as follows:

1. The facility administrator, with the medical consultant, shall establish written medical and administrative policies governing the provision of medical services to the participants;

2. Any medical services required (including podiatry services, see N.J.A.C. 10:57–1.11) shall be coordinated by the participant's attending physician;

3. If the participant has no attending physician, the facility shall assist the participant to secure one;

4. The participant may choose the medical consultant as his or her attending physician, provided the medical consultant becomes the participant's attending physician with all the responsibilities attendant to such a role over a 24–hour period on a continuing basis;

5. An individual medical record shall be maintained for each participant; and

6. The attending physician shall provide medical orders for treatment of participants, which shall include medication; diet; activities permitted; therapies, such as physical therapy, occupational therapy, and speech-language pathology services; and other services as necessary (that is, laboratory tests, dental, etc.).

8:43F–5.6 Designation of medical consultant

A physician shall be designated to serve as medical consultant.

8:43F–5.7 Medical consultant's responsibilities

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

1. Assisting the facility in developing written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the medical service;

2. Assisting in the coordination and integration of medical services with other participant care services to provide a continuum of care for the participant; and

3. Reviewing written medical policies in cooperation with the physicians responsible for providing care to the participants.

(b) The medical consultant may be an attending physician for participants.

8:43F–5.8 Responsibilities of physicians

(a) A physician and an alternate physician shall be designated for each participant, who can be contacted when necessary, including in the event of a medical emergency. The physician who provides care to the participant shall provide the following information, which shall be included in the participant's medical record:

1. A signed, dated medical history and physical examination report, including results of a chest X-ray, if performed. The history and physical examination shall be performed within 30 days prior to or upon admission to the program;

2. Certification that the participant requires the type and intensity of care provided by the facility and is free of communicable disease; and

3. Specification of the degree of participant mobility and specification of any assistive devices that the participant requires.

(b) The facility shall have a mechanism to ensure that the physician shall participate in developing, implementing, reviewing, and revising the participant's care plans.

(c) Following the initial examination, certification and orders provided by the physician, subsequent examinations and orders may be delegated to a nurse practitioner or clinical nurse specialist, certified in accordance with the Nurse Practitioner/Clinical Nurse Specialist Certification Act (N.J.S.A. 45:11–45 et seq.), and rules (N.J.A.C. 13:37), or to a New Jersey licensed physician assistant, licensed in accordance with N.J.A.C. 13:35–2B.

8:43F–5.9 Provision of nursing services

(a) The facility shall provide nursing services to participants, directly in the facility.

(b) A registered professional nurse shall be available in the facility at all times when the facility is operating. Additional licensed professional personnel shall be present in facilities where the daily attendance exceeds 60 participants. The registered professional nurse shall be responsible for the supervision of licensed and ancillary nursing staff.

(c) The registered professional nurse shall be responsible for, but not limited to, the following:

1. Interviewing the participant and caregivers in order to evaluate the participant's health status and health care needs;

2. Maintaining the standards of nursing practice including, but not limited to: monitoring of identified medical conditions, administration and supervision of prescribed medications and treatments; coordination of rehabilitative services, development of a restorative nursing plan; monitoring of clinical behavior and nutritional status; assisting with the maintenance or redevelopment of the activities of daily living skills; monitoring growth and development; implementing infection control procedures; and communicating findings to the attending physician;

3. Managing medical emergencies;

4. Documenting the nursing services provided, including the initial assessment and evaluation of the participant's health care needs, development of the nursing component of the individualized plan of care, evaluation of the participant's progress in reaching established goals and defining the effectiveness of the nursing component of the individualized plan of care;

5. Overseeing the development of the initial individualized interdisciplinary plan of care;

6. Alerting others involved with the participant's care about changes in status and the need to change the individualized interdisciplinary plan of care;

7. Developing community medical referral resources and maintaining on-going communication with those providers;

8. Linking the participant to necessary health care services outside the program;

9. Coordinating the services provided by other staff to meet the mutually identified health care and psychosocial needs of each recipient;

10. Providing in-service training to center staff about the participant's health care needs;

11. Coordinating and implementing the facility's quality assurance program in conjunction with the multidisciplinary team;

12. Providing health education for a participant's family or primary caregiver; and

13. Serving as an advocate to assist the participant/caregiver to resolve problems.

(d) The facility's nursing staff shall assure that nursing services provided to participants are coordinated with health services currently received at home, as well as with existing community health agencies and services available to participants in time of need.

8:43F–5.10 Designation of director of nursing services

(a) A registered professional nurse shall be designated in writing as the director of nursing services and shall be on duty at all times when services are being provided. A registered professional nurse shall be designated in writing to act in the director's absence.

1. Additional licensed nursing personnel and ancillary nursing personnel shall be provided in accordance with the facility's policies and procedures for determining staffing levels on the basis of an assessment of the acuity of participants.

8:43F–5.11 Responsibilities of director of nursing services

(a) The director of nursing services shall be responsible for the direction, provision, and quality of nursing services provided to participants. The director of nursing services shall be responsible for developing and implementing written objectives, standards of practice, policies and procedures and an organizational plan for the nursing service.

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

1. Procedures for the assessment of the health service needs of all participants;

2. Procedures for monitoring the conditions of the participants on a continuing basis;

3. Procedures for the notification of the administrator if there are significant changes in a participant's condition;

4. Procedures for the assessment of the participant's need for referral to a physician;

5. Procedures for maintaining records as required by the facility; and

6. A policy statement that each nurse shall serve as a resource person and health educator to the participants and to the administrator of the facility.

8:43F–5.12 Responsibilities of licensed nursing personnel

The facility shall provide nursing services and licensed nursing and ancillary personnel at all times during which the facility is open. In accordance with N.J.A.C. 13:37–6.2, the registered professional nurse may delegate selected nursing tasks in the implementation of the nursing regimen to licensed practical nurses and ancillary nursing personnel.

8:43F–5.13 Personal care services

(a) To insure quality personal care, facility staff shall make daily checks to assure that participants are maintaining personal hygiene, receiving medications as prescribed (which includes assuring the renewal of prescriptions as necessary and the disposition of outdated or discontinued drugs), and participating in appropriate social and recreational activities.

(b) Personal care services shall include education in assistance with activities of daily living (for example, walking, eating, toileting, grooming) and supervision of personal hygiene.

8:43F–5.14 Provision of pharmacy services

(a) The facility shall designate a pharmaceutical consultant, who is not the pharmacy provider and does not have an affiliation with the pharmacy provider, and is responsible, in accordance with New Jersey State Board of Pharmacy rules, N.J.A.C. 13:39, for the following:

1. Establishing written policies and procedures to ensure the safe use, labeling, storage, integrity, administration, control and accountability of all drugs stored or administered by the facility;

2. Reviewing the records of all participants at least every 90 days to assure that the medication records are accurate, up-to-date and that these records indicate that medications are administered or self-administered in accordance with physician's orders;

3. Reviewing records at least every 90 days to assure drug regimen, laboratory tests, special dietary requirements, and foods or natural or herbal medicines used or administered concomitantly with other medications to the same recipients are monitored for potential adverse reaction, allergies, drug interaction, contraindications, rationality, drug evaluation, and test modification; and that all irregularities or recommended changes are documented on the recipient's record and reported to the administrator or attending physician;

4. Providing and documenting in-service training and consultation with staff and, if appropriate, participants of the center as required to assure compliance with pharmaceutical compliance and utilization;

5. Devoting a minimum of one hour a month to carry out the responsibilities under this section; and

6. Maintaining a written record of activities, findings and recommendations.

8:43F–5.15 Drug administration policies and procedures

(a) The facility shall establish a system to accurately identify participants before any drug is administered.

(b) Medications shall be accurately administered by properly authorized individuals who shall ensure that the right drug is administered to the right person in the right dose through the right route of administration at the right time.

8:43F–5.16 Pharmacy reporting policies and procedures

(a) The consultant pharmacist shall report any irregularities to the director of nurses, who shall report to the administrator and the attending physician. These reports shall be acted upon.

(b) Medication allergies shall be documented in the participant's medical record and on its outside front cover and communicated to the provider or dispensing pharmacy.

(c) Medication errors and adverse reactions shall be reported immediately to the director of nursing or the alternate to the director of nursing, and a description of the error or adverse drug reaction shall be entered into the medical record before the end of the employee shift. If the participant has erroneously received medication, the participant's physician who prescribed the medication shall be notified immediately. If a medication error originated in the pharmacy, the pharmacy shall be notified immediately.

8:43F–5.17 Pharmacy control policies and procedures

(a) The label of each participant's individual medication container or package shall be permanently affixed and contain the following information, except as provided by (b) and (c) below:

1. The participant's full name;
2. The prescriber's name;
3. The prescription number;
4. The name and strength of the medication;
5. The quantity dispensed;
6. Directions for use;
7. The date upon which the medication is dispensed;
8. The manufacturer's name, if generic.

i. If a generic substitute is used, the medication shall be labeled in accordance with the Drug Utilization Review Formulary, N.J.S.A. 24:6E–1 et seq. and N.J.A.C. 8:71; and

9. The expiration date, if dispensed in any packaging other than the manufacturer's original packaging, and in accordance with N.J.A.C. 13:39–5.9.

(b) If medications are dispensed to participants from out-of-State pharmacies, the facility shall request in writing each pharmacy to label medications in accordance with (a) above.

(c) The dispensed container for any product shall bear all auxiliary labeling as recommended by the manufacturer and/or as deemed appropriate in the professional judgement of the dispensing pharmacy.

(d) Alternative medication delivery systems, such as unit-of-use, unit dose or customized medication packages, shall be labeled, dispensed, stored, accounted for, and monitored in accordance with the New Jersey State Board of Pharmacy rules, N.J.A.C. 13:39, the United States Pharmacopoeia, and generally accepted standards of pharmaceutical practice for drug distribution systems. Required information appearing on individually packaged medications or within an alternative medication delivery system need not be repeated on the label.

(e) Over-the counter (OTC) medications may be kept as stock. These medications shall be approved by the pharmacy consultant, monitored for accountability, and labeled to include medication name, strength, manufacturer's name, lot number, expiration date, recommended dosage for OTC use (if repackaged), and applicable cautionary and/or accessory labeling.

8:43F–5.18 Rehabilitation/habilitation services

(a) Rehabilitative/habilitative services, which include physical therapy, occupational therapy, and speech-language pathology services, shall be provided by the facility to those participants whose need for these services has been definitely described in the individualized plan of care and ordered by the attending physician.

(b) Physician orders for speech-language pathology, physical therapy, occupational therapy, and audiology services shall include specific modalities and the frequency of treatment, and shall be entered into the participant's medical record.

(c) Physician orders for medically appropriate speech-language pathology, physical therapy, and audiology services shall be properly followed, and the results of these services shall be entered into the participant's medical record.

(d) Appointments for speech-language pathology evaluation, physical therapy evaluation, occupational therapy evaluation, and audiology evaluation shall be made within five days of the participant's program attendance.

8:43F–5.19 Rehabilitation/habilitation supplies and equipment

(a) Space for rehabilitation therapy and/or habilitation services shall be provided in the facility, or, if space is unavailable, arrangements shall be made for transportation of participants who require rehabilitation therapy and/or habilitation services.

(b) Visual privacy and provisions for auditory privacy shall be provided for participants during evaluation and rehabilitation and/or habilitation treatment, when clinically indicated.

(c) If the facility provides physical therapy on-site, physical therapy equipment available to the participants shall include at least parallel bars, stairs, mats, and padded tables.

8:43F–5.20 Provision of social work services

(a) The facility shall arrange for the provision of social work services to participants who require them, in accordance with N.J.S.A. 45:15BB–1 et seq. and N.J.A.C. 13:44G.

(b) The social work staff shall provide, but not be limited to, the following social services:

1. Interviewing the participant and caregiver to obtain a social assessment and evaluation of needs and problems;

2. Providing or arranging for individual, family and group counseling in reference to psychological, social, financial, legal, vocational, and educational needs of the participant;

3. Assisting with obtaining concrete services; for example, housing, shopping, clothing etc.;

4. Referring to and/or developing support groups and educational programs for caregivers and participants;

5. Arranging and/or providing crisis intervention;

6. Providing family outreach;

7. Coordinating participant's care plans with other community resources;

8. Providing in-service training to staff on participant/caregiver psychosocial needs;

9. Participating in the facility's quality assurance program;

10. Participating in professional organizations and seminars;

11. Participating in participants' case conferences; for example, pre-admissions and post-admissions, problem-oriented cases; and

12. Documenting assessments, treatment plans, evaluations and clinical notes (as defined at N.J.A.C. 8:43F–1.2).

(c) A social worker shall provide social work services in the facility for at least 30 minutes per week per participant equivalent, calculated on the basis of the daily census.

8:43F–5.21 Provision of activities services

(a) Activities staff shall arrange a diversity of programs to maintain adult participants' sense of usefulness and self-respect.

(b) Activities programs shall take place in individual and group settings, on an ongoing basis.

(c) Facility activities programs shall be available to all participants regardless of their financial status, with the exception of special events for which there is a charge for all participants.

8:43F–5.22 Designation of activities director

(a) The facility shall designate an activities director who shall be responsible for the direction, provision, and quality of the activities service. The activities director shall be responsible for, but not limited to, the following:

1. Participating in developing and implementing written objectives, policies, a procedure manual, and an organizational plan;

2. Participating in the facility's quality assurance program;

3. Ensuring that services are provided and are coordinated with other services to provide a continuum of care for the participant;

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

5. Developing and posting a current monthly activities schedule where it can be read by participants, staff, and visitors, and maintaining a record of such schedules for one year.

(b) Facility staff, under the direction of the activities director, shall provide a planned program of social, physical, spiritual, psychological and cognitive activities. The activities shall reflect and be adapted to the needs, interests and capabilities of the participants.

1. The facility may involve volunteers in the implementation of the activities program.

2. Activities shall include, but not be limited to:

i. Discussion groups (reality orientation, remotivation);

ii. Arts and crafts;

iii. Specialty groups;

iv. Exercise groups;

v. Educational programs;

vi. A participant council;

vii. Special events (parties, entertainment);

viii. Excursions or outings;

ix. Community service projects; and

x. Individualized programs.

3. The participants and their families, when possible, shall be involved in the planning and implementation of the activities program.

4. The activity staff shall:

i. Participate in all participant conferences;

ii. Participate in professional organizations and seminars;

iii. Document assessments, treatment plans, evaluations and clinical notes; and

iv. Participate in the facility's quality assurance program.

8:43F–5.23 Transportation services

(a) The facility shall provide safe transportation services, either directly or through contractual arrangements, to all participants who require transportation between the facility and the participant's home. No participant's total daily transportation time shall exceed two hours.

(b) Vehicles shall be maintained in safe operating order.

(c) The facility shall maintain insurance on the vehicles.

(d) The facility shall comply with all applicable Department of Transportation rules promulgated under N.J.S.A. 39:1–1 et seq.

SUBCHAPTER 6. STAFF REQUIREMENTS

8:43F–6.1 Mandatory staffing requirements

(a) The facility shall have adequate staff capability to provide services and supervision to the participants at all times. The composition of the staff shall depend in part on the needs of the participants and on the number of participants the program is serving. At a minimum, the facility shall have an administrator/director, a registered professional nurse, a social worker, an activities director and a medical consultant, as well as having a registered pharmacist and a qualified dietitian as consultants.

(b) Adult day health services facilities shall provide at least one full-time, or full-time equivalent, direct care staff member for every nine participant equivalents, calculated on the basis of the daily census. Additional staff members shall be provided when assessment of the acuity of participants indicates that additional staff members are required, in accordance with the facility's policies and procedures for determining staffing levels.

1. Without compromising the above required staff-participant ratio of one to nine for day health services facilities serving adults, various staff positions could combine functions within one person, that is, the administrator/director may be a social worker or activities director, performing dual functions of the director/social worker or the director/activities director. In adult day health services facilities serving adults with 36 or more participants the director may not serve a dual function. New adult pro-

grams for start-up purposes, or with less than 10 participants, may have no fewer than two full time staff persons. The registered professional nurse shall occupy one of these positions.

(c) The facility shall maintain a daily record of participant attendance for each day during which services are provided.

(d) If a health care facility licensed by the Department provides adult day health services in addition to other health care services, the facility shall adhere to the rules in this chapter and to the rules for licensure of facilities providing the other health care services.

(e) Except in an emergency, facilities shall not provide program services to individual participants for more than 12 consecutive hours during any calendar day of the year without prior written approval by the Department.

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

8:43F–6.2 Personnel

(a) The facility shall make reasonable efforts to ensure that staff providing direct care to participants in the facility are in good physical and mental health, emotionally stable, of good moral character, are concerned for the safety and well-being of participants, and have not been convicted of a crime relating adversely to the person's ability to provide care to participants, except where the applicant or employee with a criminal history has demonstrated his or her rehabilitation, to the satisfaction of the license holder, in order to qualify for employment at the facility.

1. "Reasonable efforts" shall include, but not be limited to, an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.

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

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

(d) The facility shall maintain written staffing schedules. Staffing schedules shall be implemented to ensure continuity of care.

(e) The facility shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of person(s) responsible for training.

1. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, emergency plans and procedures, the infection prevention and control services, and elder abuse.

(f) Employee health records as required by these rules shall be maintained for each employee. Employee health records shall be confidential and kept separate from personnel records and shall include documentation of all medical screening tests performed and the results.

8:43F–6.3 Qualifications of the administrator of the adult day health services facility

(a) The administrator of an adult day health services facility shall:

1. Have a master's degree from a college or university approved by a state department of education and at least one year of full-time, or full-time equivalent, administrative or supervisory experience in a licensed health care facility;

2. Have a baccalaureate degree from an approved college or university and three years of full-time or full-time equivalent experience in a licensed health care facility; or

3. Be a qualified health professional licensed by the State of New Jersey, such as a nursing home administrator, physician, social worker, licensed physical therapist, occupational therapist, or speech-language pathologist with at least one year of full-time, or full-time equivalent, administrative or supervisory experience in a licensed health care facility.

(b) In an adult day health services facility serving adults, the administrator shall be experienced in the care of the elderly and disabled and knowledgeable regarding their physical, social and medical health needs.

8:43F–6.4 Qualifications of the director of nursing services

The director of nursing services shall be a registered professional nurse who has at least one year of full-time, or full-time equivalent, experience in nursing supervision and/or nursing administration in a licensed health care facility.

8:43F–6.5 Qualifications of food service supervisors

(a) The food service supervisor shall:

1. Be a dietitian;

2. Be a graduate of a dietetic technician or dietetic assistant training program approved by the American Dietetic Association (Office on Dietetic Credentialing, 216 Jackson Boulevard—7th Floor, Chicago, Illinois 60606–6995); or

3. Be a graduate of a New Jersey State-approved course in food service management and have at least one year of full-time, or full-time equivalent, experience as a food service supervisor in a licensed health care facility.

8:43F–6.6 Qualifications of activities director

(a) The activities director shall:

1. Be certified or eligible for certification as an activity director certified (ADC) by the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, P.O. Box 62589, Virginia Beach, VA 23466);

2. Be certified or eligible for certification as a certified therapeutic recreation specialist (CTRS) by the National Council for Therapeutic Recreation (National Council for Therapeutic Recreation, Inc., 7 Elmwood Drive, New City, NY 10956);

3. Have a baccalaureate degree from a college or university approved by a state department of education with a major in recreation, creative arts therapy, music therapy, therapeutic recreation, art, art education, psychology, sociology, occupational therapy, or other health and/or human services related degree such as gerontology or early education;

4. Have a high school diploma and at least three years of full-time, or full-time equivalent, experience in activities in a licensed health care facility and have successfully completed an activities education program approved by the New Jersey Department of Health and Senior Services after a review of the specific curriculum, consisting of 90 hours of training and incorporating the following elements:

i. Overview of the activity profession;

ii. Human development: the late adult years, or for pediatric facilities, early childhood years;

iii. Standards of practice/practitioner behavior;

iv. Activity care planning for quality of life; and

v. Methods of service delivery in the activity profession; or

5. Have served as director of activities continuously since February 20, 1990.

(b) Activities directors who have been continuously employed and who have completed an activities education course which was previously approved by the Department shall not be required to complete the course described at (a)4 above in order to continue in their present position.

SUBCHAPTER 7. FACILITY

8:43F–7.1 Administrator's responsibilities for infection control

(a) The administrator shall ensure the development and implementation of an infection prevention and control program.

(b) The administrator shall designate a person who shall be responsible for the direction, provision, and quality of infection prevention and control services. The designated person shall be responsible for, but not limited to, developing and maintaining written objectives, a policy and procedure manual, an organizational plan, and a quality assurance program for the infection prevention and control service.

8:43F–7.2 Infection control policies and procedures

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

1. Guideline for Handwashing and Hospital Environmental Control, PB85–923404;

2. OSHA Standards 29 CFR–1910.1030, Bloodborne pathogens as amended and supplemented;

3. Prevention and Control of Tuberculosis in Facilities Providing Long–Term Care to the Elderly, and contained in MMWR 39(RR–10); and

4. Prevention of Nosocomial Pneumonia, PB95–176970.

(b) Centers for Disease Control publications can be obtained from:

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161
(703)605–6000
(800)553–6847
or
Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

(c) The facility shall document evidence of annual vaccination against influenza for each adult participant, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccination, incorporated herein by reference, unless such vaccination is medically contraindicated or the participant has refused the vaccine, in accordance with N.J.A.C. 8:43F–4.4(a)3. Influenza vaccina-

tion for all participants accepting the vaccine shall be completed by November 30 of each year. Participants admitted after this date, during the flu season and up to February 1, shall, as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the participant.

(d) The facility shall document evidence of vaccination against pneumococcal disease for all participants who are 65 years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccination, incorporated herein by reference, unless such vaccination is medically contraindicated or the participant has refused offer of the vaccine in accordance with N.J.A.C. 8:43F–4.4(a)3. The facility shall provide or arrange for pneumococcal vaccination of participants who have not received this immunization, prior to or on admission unless the participant refuses offer of the vaccine.

(e) Each pediatric day health services facility shall maintain an up-to-date immunization record for each participant which is appropriate to the child's age in accordance with N.J.A.C. 10:122–7.3(a)2iii and 7.3(a)5 and 6, or documentation that the child is under a prescribed medical program to obtain immunizations in accordance with the provisions of N.J.A.C. 8:57–4.

(f) Each new employee upon employment and each participant upon admission shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees or participants with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees or participants with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees or participants who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees or participants shall be acted upon as follows:

1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later;

2. If the Mantoux test is significant (10 millimeters or more of induration), a chest x-ray shall be performed and, if necessary, followed by chemoprophylaxis or therapy;

3. Any employee with positive results shall be referred to the employee's personal physician and if active tuberculosis is suspected or diagnosed shall be excluded from work until the physician provides written approval to return; and

4. Any participant with positive results shall receive care in accordance with N.J.A.C. 8:43F–7.2(a)3.

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

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

(i) The facility shall report at least semi-annually the results of all tuberculin testing of personnel and participants to the Department of Health and Senior Services, Division of Epidemiology, Tuberculosis Program, on forms provided by the Department.

(j) Written infection control policies and procedures shall include, but not be limited to, policies and procedures for the following:

1. In accordance with Chapter II, New Jersey State Sanitary Code, N.J.A.C. 8:59, a system for investigating, reporting, and evaluating the occurrence of all infections or diseases which are reportable or conditions which may be related to activities and procedures of the facility, and maintaining records for all participants or personnel having these infections, diseases, or conditions;

2. Infection control in accordance with OSHA Standards 29 CFR-1910.1030 Bloodborne pathogens as amended and supplemented, incorporated herein by reference;

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

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

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

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

7. The prevention of decubitus ulcers; and

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

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

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

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

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

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

(*l*) Disinfection procedures for items that come in contact with bed pans, sinks, and toilets shall conform with established protocols for cleaning and disinfection.

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

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

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

8:43F–7.3 Employee health history and examinations

(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or nurse practitioner/certified nurse specialist, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment upon employment, the physician's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the content and frequency of physical examinations for employees, and shall develop policies which specify the circumstances under which other persons providing direct participant care services shall receive a physical examination.

(b) The facility shall develop and implement policies and procedures to ensure that all volunteers and students who have direct participant care responsibilities on a routine basis provide documentation that they have received, at a minimum, a Mantoux tuberculin skin test and either a physical examination or a certification of health status from a physician.

(c) Yearly influenza immunization shall be offered to employees at no charge.

8:43F–7.4 Regulated medical waste

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

(b) The facility shall comply with the provisions of N.J.S.A. 13:1E–48.1 et seq., the Comprehensive Regulated Medical Waste Management Act, and all rules promulgated pursuant to the aforementioned Act, including N.J.A.C. 7:26–3A.

8:43F–7.5 Provision of housekeeping, sanitation, and safety

(a) The facility shall provide and maintain a sanitary and safe environment for participants.

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

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

8:43F–7.6 Housekeeping

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

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

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

8:43F–7.7 Participant environment

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

1. The facility and its contents shall be free of dirt, debris, and insect and rodent harborages;

2. Nonskid wax shall be used on all waxed floors;

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

4. All participant areas shall be free of noxious odors;

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

6. All furnishings shall be clean and in good repair, and mechanical equipment shall be in working order. Equipment shall be kept covered to protect from contami-

nation and accessible for cleaning and inspection. Broken or worn items shall be repaired, replaced, or removed promptly;

7. All equipment shall have unobstructed space provided for operation;

8. All equipment and materials necessary for cleaning, disinfecting, and sterilizing shall be provided;

9. Thermometers which are accurate to within three degrees Fahrenheit shall be maintained in refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration;

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

11. Articles in storage shall be elevated from the floor and away from walls;

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

13. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater located in an open basement;

14. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored in closed metal cabinets or containers;

15. Unobstructed aisles shall be provided in storage areas;

16. A program shall be maintained to keep rodents, flies, roaches, and other vermin out of the facility;

17. Toilet tissue, soap dispenser, paper towels or air dryers, and waste receptacles shall be provided in each bathroom at all times;

18. All solid or liquid waste that is not regulated medical waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey Department of Environmental Protection and the New Jersey Department of Health and Senior Services. Solid waste shall be stored in insectproof, rodentproof, and fireproof, nonabsorbent, watertight containers with tight fitting covers and collected from storage areas regularly so as to prevent nuisances such as odors. Procedures and schedules shall be established and implemented for the cleaning of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24;

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

20. Plastic bags shall be used for solid waste removal. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal;

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

22. Wastebaskets and ashtrays shall be made of noncombustible materials;

23. Latex foam pillows shall be prohibited;

24. The temperature of the hot water used for bathing and handwashing shall not exceed 110 degrees Fahrenheit;

25. Equipment requiring drainage, such as ice machines, shall be drained to a sanitary connection; and

26. The temperature in the facility shall be kept at a minimum of 70 degrees Fahrenheit and a maximum of 85 degrees Fahrenheit when participants are in the facility.

8:43F–7.8 Physical plant

(a) Construction standards for freestanding facilities for new buildings and alterations, renovations, and additions to existing buildings for freestanding adult day health services facilities shall comply with the New Jersey Uniform Construction Code, N.J.A.C. 5:23–3.2.

(b) Construction standards for facilities within long-term care facilities for new buildings and alterations, renovations, and additions for adult day health services facilities in existing buildings which are part of long-term care facilities shall comply with the New Jersey Uniform Construction Code, N.J.A.C. 5:23–3.2.

(c) Prior to any construction, plans shall be submitted to the Department of Community Affairs for review.

8:43F–7.9 Provision for the handicapped

Facilities shall be available and accessible to the physically handicapped pursuant to the New Jersey Uniform Construction Code, N.J.A.C. 5:23–7, Barrier Free Subcode.

8:43F–7.10 Functional service areas

(a) Each adult or pediatric day health services facility shall provide the following service areas on-site:

1. Administration services;
2. Employees' facilities;
3. Housekeeping services;
4. Social work services;
5. Activities;
6. Nursing services, pharmacy services, medical services, and
7. Dietary services.

(b) Toilet facilities shall be provided to meet the needs of participants, staff and visitors.

1. The number of toilet facilities shall be based on one toilet and one sink for every 10 adult participants. Within the one to 10 toilet ratio, there shall be included a minimum of one single occupant handicap toilet room for participants who need assistance with toileting. (Urinals may be substituted for no more than 20 percent of the required toilets.)

2. Pediatric day health services facilities shall have one toilet and one sink for every 15 children as well as two diaper changing areas within 15 feet of a handwashing sink.

8:43F–7.11 Administration areas

(a) The entrance shall be located at grade level and shall accommodate wheelchairs and other assistive devices.

(b) The facility shall make provisions for conducting private interviews related to credit and admission.

(c) General or individual office(s) for business transactions, records, administrative, and professional staffs shall be provided.

(d) Clerical space or rooms for typing, clerical work, and filing shall be provided.

(e) General storage facilities for supplies and equipment shall be provided as needed for continuing operation.

8:43F–7.12 Employee facilities

Employee facilities such as lockers and lounges shall be provided for employees and volunteers.

8:43F–7.13 Housekeeping services

A janitor's closet shall be provided, on each floor or immediately accessible, which shall contain a service sink and storage for housekeeping supplies and equipment.

8:43F–7.14 Social work services

The social work service shall include office space for private interviewing and counseling, waiting space, and record storage area.

8:43F–7.15 Activities area

(a) A facility shall have a total of 30 square feet per person for activities and dining. The dining area shall accommodate all participants simultaneously at each meal.

(b) Storage space shall be provided for recreational equipment and supplies.

(c) An office or area for the activities director shall be provided.

8:43F–7.16 Nursing service

(a) Each adult facility shall provide comfortable furniture for participants who wish to rest or recline. Such furniture shall be selected to meet the assessed needs of participants, and one item of furniture shall be available for every 10 participants, based upon the daily census. A separate, quiet area for resting shall be available for adult participants.

(b) A drinking fountain or bottled water shall be provided.

(c) Office space for nursing staff shall be provided. This space may also serve as the pharmacy area. The following shall be provided for pharmaceutical services:

1. A dispensing area with a handwashing facility;

2. Space for a locked storage cart or locked cabinets; and

3. A separate lockable refrigerator or a locked box within a refrigerator for storage of medications.

(d) A storage area for equipment and supplies shall be provided.

(e) An examination room or private treatment space shall be provided and shall have a minimum floor area of 80 square feet, including an area for the storage of participant charts. Handwashing facilities and a counter or shelf space for writing shall be provided.

8:43F–7.17 Dietary service

(a) The construction, equipment, and installation of food service facilities shall meet the requirements of the functional program. Services may consist of an on-site conventional food preparation system, a convenience food service system, a catering service or an appropriate combination thereof. The following facilities shall be provided to implement the food service selected:

1. A control station for receiving food supplies;

2. Storage facilities for food supply, including cold storage items;

3. Food preparation facilities as follows:

i. A conventional food preparation system with space and equipment for preparing, cooking and baking; and

ii. A convenience food system, such as frozen prepared meals, bulk packaged entrees, individually packaged portions, and contractual commissary services with space and equipment for thawing, portioning, cooking, and/or baking;

4. Handwashing facility(ies), located in the food preparation area;

5. Warewashing space, which shall be located in the kitchen or an alcove separate from the food preparation and serving area;

6. Waste storage facility(ies), which shall be located in a separate room easily accessible to the outside for direct waste pickup or disposal; and

7. Office(s) or desk space(s) for dietitian(s) or the food service manager.

8:43F–7.18 Occupational therapy service

(a) If occupational therapy services are provided on site, the following areas shall be provided:

1. Office space (may be shared with general offices);

2. Activity areas; and

3. Storage for supplies and equipment.

(b) The areas designated in (a) above may be planned and arranged for shared use by physical therapy participants and staff, if the program reflects this sharing concept.

8:43F–7.19 Physical therapy service

(a) If physical therapy services are provided on-site, the following spaces shall be provided:

1. Office space;

2. Treatment area(s)with a handwashing sink; and

3. An exercise area.

(b) The areas designated in (a) above may be planned and arranged for shared use by occupational therapy participants and staff, if the program reflects this shared concept.

8:43F–7.20 Speech language pathology and audiology service

(a) If speech language pathology and audiology services are provided on-site, the following shall be provided:

1. Office space for the therapist;

2. Space for evaluation and treatment; and

3. Space for equipment and storage.

8:43F–7.21 Nutritional counseling

Nutritional counseling may be provided in the dietitian's office or in a conference room, based on program requirements.

8:43F–7.22 Laundry service

(a) If laundry services are provided on-site, the following areas shall be provided:

1. A laundry processing room;

2. Separate, clearly identified covered waste containers for soiled linens and/or soiled disposables in a designated area away from participant activities and dining area;

3. Storage for laundry supplies;

4. A clean linen or disposables storage, issuing and holding room or area; and

5. A janitor's closet, containing a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(b) If linen is processed off-site, the following areas shall be provided:

1. A receptacle for holding soiled linen; and

2. A clean linen and/or disposables receiving, holding, inspection, and storage room(s) or area.

SUBCHAPTER 8. PEDIATRIC DAY HEALTH SERVICES FACILITIES

8:43F–8.1 Services

(a) Each pediatric day health services facility shall comply with the applicable provisions in N.J.A.C. 8:43F–1 through 7.

(b) Pediatric day health care services shall be provided for a minimum of six hours per day, exclusive of transportation time, not to exceed five days per week.

(c) Each pediatric day health services facility shall have a system to ensure that each child's nutritional needs are met, based upon individual assessments. Parents may send foods with participants or foods may be prepared in the facility, in accordance with facility policies and procedures. The facility shall ensure that appropriate snacks and fluids are available for each child.

(d) Each pediatric day health services facility shall have arrangements for the provision of services by appropriate pediatric specialists (for example, pulmonologists, cardiologists).

(e) A medical evaluation of all participants shall be provided or arranged for by the medical consultant as needed, but at least every 60 days. The documented components of the medical evaluation for children shall be a history and physical, including developmental status, immunization status, laboratory data and a clear identification of medical needs.

(f) In pediatric day health services facilities, activities of daily living include appropriate developmental stimulation, diaper changing, and toilet training.

(g) A diversified program of activities for pediatric participants shall be planned and implemented, based on evaluation of the developmental status and needs of each child.

(h) The records of all pediatric participants shall be reviewed by the pharmaceutical consultant at least every 60 days to assure that the medication records are accurate, up-to-date and that these records indicate that medications are administered or self-administered in accordance with physician's orders.

(i) Pediatric records shall be reviewed by the pharmaceutical consultant at least every 60 days to assure drug regimen, laboratory tests, special dietary requirements, and foods used or administered concomitantly with other medications to the same recipients, are monitored for potential adverse reaction, allergies, drug interaction, contraindications, rationality, drug evaluation, and test modification; and that all irregularities or recommended changes are documented on the participant's record and reported to the medical consultant or attending physician.

(j) The record shall be protected against loss, destruction, or unauthorized use. Medical records shall be retained for a period of 10 years following the most recent discharge of the participant or until the participant reaches the age of 23 years, whichever is the longer period of time, a summary sheet shall be retained for a period of 20 years, and X-ray films or reproductions thereof shall be retained for a period of five years, in accordance with N.J.S.A. 26:8–5.

(k) If a health care facility licensed by the Department provides pediatric day health services in addition to other health care services, the facility shall adhere to the rules in this chapter and to the rules for licensure of facilities providing the other health care services.

(*l*) A pediatric day health care facility may retain a participant who is more than 18 years of age, with a physician's order and assessment on at least a quarterly basis by the registered professional nurse to assure that the participant's needs are met.

8:43F–8.2 Staffing

(a) In pediatric day health services facilities, the ratio shall be one staff person to three children. There shall be at least two registered professional nurses available to participants of the facility, including one registered professional nurse on the premises of the pediatric day health services facility during all hours of operation. The ratio shall include the administrator/director and all other personnel (except the medical consultant) who are involved in direct participant care, excluding volunteers. Additional staff members shall be provided when assessment of the acuity of participant need indicates that additional staff members are required, in accordance with the facility's policies and procedures for determining staffing levels.

1. Without compromising the above required staff-participant ratio of one to three for pediatric day health services facilities, various staff positions could combine functions within one person, that is, the administrator/director may be a social worker or activities director, performing dual functions of the director/social worker or the director/activities director.

(b) When there are technology dependent children served in the facility, a registered professional nurse certified for intravenous administration must be available during the hours of operation.

8:43F–8.3 Use of restraints

In pediatric day health care facilities, pediatric safety guards may be used, in accordance with assessments and care plans.

8:43F–8.4 Provision of cribs or mats

(a) Pediatric facilities shall provide one crib or sleeping mat for each child.

(b) Pediatric day health care facilities shall provide space for one crib and/or sleeping pad for each child.

8:43F–8.5 Staff qualifications

(a) In a pediatric day health services facility, one of the on duty registered professional nurses shall have, at a minimum, the following credentials:

1. Possess a Bachelor of Science in Nursing degree; or

2. Have at least one year full-time pediatric experience.

(b) In pediatric day health services facilities, the director of nursing shall have pediatric nursing experience.

(c) In a pediatric day health services facility, the administrator/director shall be a qualified health professional, such as a physician, licensed social worker or licensed clinical social worker with a pediatric concentration; a registered professional nurse with a Master of Science (MSS), or Bachelor of Science in Nursing (BSN), or Pediatric Nurse Practitioner (PNP), with pediatric experience.

(d) For pediatric day health services facilities, all direct care staff shall have current certification in cardio-pulmonary resuscitation (CPR) and shall have had pediatric experience. Those without recent pediatric experience shall be educated by the facility in growth and development and in the care of children with special needs.

(e) The medical consultant of a pediatric facility shall be board certified or eligible in pediatrics.

(f) All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at minimum, emergency plans and procedures, the infection prevention and control services, identification of child abuse.

(g) In pediatric facilities, the social worker shall have experience in providing social services to children.

(h) In pediatric facilities, the activities director shall have experience in planning and implementing activities for children, in addition to meeting the qualifications of activities director at N.J.A.C. 8:43F–6.6(a).

(i) Staff employed by a pediatric day health services facility shall have had pediatric experience or shall be educated by the facility in growth and development and in the care of children with special needs, and shall be provided with ongoing training regarding children with special needs.

8:43F–8.6 Facility

(a) Construction standards for freestanding facilities for new buildings and alterations, renovations, and additions to existing buildings for freestanding pediatric day health care facilities shall comply with the New Jersey Uniform Construction Code, N.J.A.C. 5:23–3.2.

(b) Construction standards for facilities within long-term care facilities for new buildings and alterations, renovations, and additions for pediatric day health care facilities in existing buildings which are part of long-term care facilities shall comply with the New Jersey Uniform Construction Code, N.J.A.C. 5:23–3.2.

APPENDIX A

New Jersey Department of Health and Senior Services
Office of Provider Enrollment
PO Box 367
Trenton, NJ 08625-0367

PROVIDER APPLICATION

1. Legal Name of Provider	2. Type of Business of Facility
3. Business Name, if different from above	4. Federal Employer ID Number
5. Street Address of Service Location Only	6. County
7. City State Zip Code	8. Length of Time at Address

9. Billing Address (for payments)

10. Mailing Address (for correspondence)

11. Name of Nursing Home Administrator, Chief Executive Officer or Other Responsible Official

12. Nursing Home Administrator License No. and Effective Date	13. Telephone Number

14. Indicate the legal status of your organization:

☐ Profit ☐ Private ☐ Municipal ☐ Charity ☐ County
☐ Non-Profit ☐ Public ☐ State ☐ School Nurse ☐ Other, Specify _____

15. List the specific service(s) for which you are requesting approval for reimbursement under the Medicaid Program:

16. Do you operate from more than one location?

☐ Yes ☐ No If yes, list all other subsidiary or affiliated organizations below:

	Name	Service Address
1.		
2.		
3.		

(Attach additional sheets if necessary.)

17. Are you a member of a chain organization?

☐ Yes ☐ No

If yes, indicate name: _____

18. Do you require a Certificate of Need under the Health Facilities Planning Act from the New Jersey Department of Health and Senior Services?

☐ Yes ☐ No

If yes, attach a copy of the Certificate of Need. If no, explain why you do not require a certificate.

19. Does your business or facility require a license / permit?

☐ Yes ☐ No

If Yes, indicate type and number: _____
Attach a copy of the license/permit.

20. Do you require certification, accreditation or approval?

☐ Yes ☐ No

If Yes, specify type: _____

Attach a copy of the certification, accreditation or approval.
For example: N.J. Department of Health and Senior Services (clinics); State Board of Dentistry (dental clinics); State Board of Pharmacy (providers offering pharmaceutical services).

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PROVIDER APPLICATION, Continued

Legal Name of Provider	Federal Employer ID Number

21. Approved by Medicare?

☐ Yes ☐ No

If Yes, indicate Medicare Provider Number: _____
Attach a copy of your Medicare approval.

22. Are you currently or have you ever been an approved provider of services under the New Jersey Medicaid Program or the Medicaid Program of any other state or jurisdiction?

☐ Yes ☐ No

If yes, list types of services provided and current status. If you were approved at one time and you no longer participate, explain the reason(s).

23. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been the subject of any license suspension, revocation, or other adverse licensure action in this state of any other jurisdiction?

☐ Yes ☐ No

If yes, explain.

24. Have any of the entities named in response to Questions 1 of 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been indicted, charged, convicted of, or pled guilty or no contest to any federal or state crime in this state or any other jurisdiction?

☐ Yes ☐ No

If yes, explain.

25. Have any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the individuals named in response to Question 11 ever been the subject of any Medicaid (Title XIX) or Medicare (Title XVIII) suspension, debarment, disqualification or recovery action in this state or any other jurisdiction?

☐ Yes ☐ No

If yes, explain.

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PROVIDER APPLICATION, Continued

Legal Name of Provider	Federal Employer ID Number

26. Do any of the entities named in response to Questions 1 or 16 or their officers or partners, or any of the other individuals named in response to Question 11 own or have any financial interest in any other provider participating in the New Jersey Medicaid (Title XIX) Program or the Medicaid Program of any other state or jurisdiction?

☐ Yes ☐ No

If yes, list provider name and nature of relationship.

27. Do you charge for goods and/or services?

☐ To All ☐ To None ☐ To Certain Groups Only

If you charge to all or only certain groups, please explain your arrangement and attach a copy of your fee schedule.

28. List days and hours of operation.

29. List the Names, Social Security Number, Date of Birth, License/Permit Number and Title or Degree(s) for all professional staff in the organization. Include physicians, dentists, psychologists, pharmacists, registered nurses, licensed practical nurses, registered physical therapists, optometrists, etc. [NOTE: Not required for health care providers certified for Medicaid and/or Medicare participation by the New Jersey Department of Health and Senior Services and/or the Health Care Financing Administration (HCFA.]

Name	Title/Degree (MD, DO, Ph.D., CPO, etc)	SSN	Date of Birth	License Permit No.
1.				
2.				
3.				
4.				
5.				
6.				
7.				

(Attach additional sheets if necessary.)

CERTIFICATION

For the purpose of establishing eligibility to receive direct payment for services to recipients under the New Jersey Medicaid (Title XIX) Program, I certify that the information furnished on this application is true, accurate, and complete. I am aware that if any of the statements made by me in this application are willfully false, I am subject to punishment, including but not limited to suspension, debarment or disqualification from the New Jersey Medicaid Program in accordance with N.J.A.C. 10:49-1.17(d)22. I agree to notify the New Jersey Department of Health and Senior Services, Office of Provider Enrollment, at least quarterly, of all future additions to any of those named in Questions 23 - 26, for whom the response to those same questions would be affirmative.

Name of Provider Representative	Title

Signature	Date

FOR STATE USE ONLY

☐ Approve ☐ Disapprove ☐ Other Initial _____ Date _____

Provider Type(s)	Category of Service	Specialty

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APPENDIX B

New Jersey Department of Health and Senior Services
New Jersey Medicaid Program
Title XIX (Medicaid)

PARTICIPATION AGREEMENT
BETWEEN

NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

AND

_____
(Medical Day Care Program - Adults)

Name and Address of Facility	State License Number
	Medicaid Provider Number

This contract, made and entered into by and between the Department of Health and Senior Services, hereinafter designated as the Department, and the above-named Facility, a provider of services, hereinafter designated as the Facility. Witnesseth:

WHEREAS, various persons eligible for benefits under the New Jersey Medicaid Program are in need of medical day care, as more specifically set forth in Program regulations and guidelines; and

WHEREAS, Section 1902(a)(27) of Title XIX of the Social Security Act requires states to enter into a written agreement with every person or institution providing services under the State Plan for medical Assistance (Title XIX); and

WHEREAS, pursuant to N.J.S.A. 30:4D-1 et seq., and the Reorganization Plan 001-1996, the Department administers this segment of the Medicaid Program and is authorized thereunder to take all necessary steps for the proper and efficient administration of the New Jersey Medicaid Program; and

WHEREAS, to participate in the New Jersey Medicaid Program, a Medical Day Care Facility must:

(1) be licensed under the laws of New Jersey as a non-residential Adult Day Health Care Center by the Department;
(2) be currently meeting, on a continuing basis, standards for licensure;
(3) be administered by a qualified health professional;
(4) meet on a continuing basis Federal and State standards for participation and, more specifically, Medical Day Care standards in Title XIX of the Social Security Act; and
(5) accept the terms and conditions of participation set out herein.

NOW, THEREFORE, it is agreed, by both parties, as follows:

A. FACILITY AGREES:

1. That it will render all services which are required for participation in the Medical Day Care program for adults, including at a minimum: medical services, nursing services, social services, transportation, personal care services, dietary services, therapeutic activities, pharmaceutical and rehabilitation services.

2. That it will accept the Medical Day Care rate approved under the Medicaid Program as payment in full and will not make any additional charges to the participant or others on his behalf for Medicaid-covered services, except for authorized physical therapy and speech-language therapy which are not included in the per diem reimbursement and must be billed separately. Medical Day Care Centers for adults will be reimbursed in accordance with methods and procedures set forth in State regulations.

MEDICAL DAY CARE PROGRAM PARTICIPATION AGREEMENT, Continued

Name and Address of Facility	Medicaid Provider Number

3. That it will promptly initiate and terminate billing procedures pursuant to applicable regulations, when individuals covered under this Program enter or leave the Facility or are assessed at a different level of care.

4. That it will limit billing procedures under this Program to those authorized participants and for those days on which Medical Day Care services have been received.

5. That it will make available to the appropriate State and/or Federal personnel or their agents, at all reasonable times and places in New Jersey, all necessary records including:

   a. Medical records as required by Section 1902(s)(27) from the Social Security Act of Title XIX and any amendments thereto;

   b. Records of all treatment, drugs, and services for which vendor payments are to be made under the Title XIX programs, including the authority for and the date of administration of such treatments, drugs, or services;

   c. Documentation in each participant's records which will enable the Department to verify that each charge is due and proper prior to payment;

   d. Financial records of the Facility, including data necessary to determine appropriate reimbursement rates; and

   e. All other records as may be found necessary by the Department to be in compliance with Federal or State law, rule, or regulations promulgated by the United States Department of Health and Human Services or by the Department.

6. That it will comply with the disclosure requirements specified in 42 CFR 455.100 through 42 CFR 455.106;

7. That the maximum number of daily participants will be in accordance with the Department's regulations and licensure standards.

8. That it will cooperate fully in permitting and assisting representatives of the Department to make assessments and evaluations of services needed by and provided to participants in general, and of individual participants who are recipients of the Medical Day Care services.

9. That it will secure and arrange for other health services as may be available for Medicaid patients pursuant to program regulations.

10. That it will comply with State and Federal Medicaid laws, and rules and regulations promulgated pursuant thereto.

11. That it will cooperate fully in permitting and assisting representatives of the Department in determining continuing conformity with the Federal and State standards applicable to non-residential Medical Day Care Facilities.

12. That it will notify the Provider Enrollment unit, within five working days, subsequent to any change in status of its license to operate as issued by the Department.

13. That it will notify the Department within five (5) working days, subsequent to any professional staff changes.

14. That it will notify the Medical Day Care participants, in writing, thirty (30) days prior to the Facility's termination as a Medicaid provider.

15. That the Facility may terminate its participation in the Medicaid Program upon a minimum of sixty (60) days written notice to the Department.

MEDICAL DAY CARE PROGRAM PARTICIPATION AGREEMENT, Continued

Name and Address of Facility	Medicaid Provider Number

16. To comply with the requirements of Title VI of the Civil Rights Acts of 1964 and Section 504 of the Rehabilitation Act of 1973 and any amendments thereto; and Section 1909 of P.L. 92-603, Section 242(c) which makes it a crime and sets the punishment for persons who have been found guilty of making any false statement or representation of a material fact in order to receive any benefit or payment under the Medical Assistance Program. (The Department is required by Federal regulation to make this law known and to warn against false statements in an application/agreement or knowing a false statement of fact used in determining the right to a benefit, or in converting a benefit, from this program, to the use of any persons other than one for whom it was intended).

17. That breach or violation of any one of the above provisions shall make this entire agreement subject to immediate cancellation at the Department's discretion, in keeping with the procedures adopted by the Department in accordance with the New Jersey Administrative Procedures Act.

18. That it will immediately provide the Department with written notice of any change in ownership and/or operation of the Facility, including changes in leases, officers and directors, stock ownership or sale of the Facility, when:

Corporate (Profit)

a. There is acquisition of or transfer of ownership through purchase, contract, donation, gift, stock option, etc., of 25% or more of a corporation's outstanding stock (preferred or common).

b. There is acquisition of the physical or intangible assets of the Facility by a newly formed or existing corporation.

Partnership

a. There is acquisition of or transfer of ownership of 10% or more of the existing partnership's total capital interest.

b. There is acquisition of the physical or intangible assets of the Facility by a newly formed or existing partnership.

Proprietorship

a. There is purchase of the physical or intangible assets of the Facility.

Corporation (Non-Profit)

a. There is a change in the officer, trustee, directors or board members of the Facility.

B. DEPARTMENT AGREES:

1. That it will pay for authorized services provided by the Facility in keeping with the availability of State appropriations, on the basis of care required by the eligible individual as determined by the Department acting under the applicable regulations, but in no event will payment be made for any individual determined not to require Medical Day Care services.

2. That it will reimburse the Medical Day Care Center through the appropriate fiscal agent in accordance with methods and procedures set forth in State regulations.

3. That it will make such payments, in accordance with applicable laws and regulations, as promptly as is feasible after a proper claim is submitted and approved.

MEDICAL DAY CARE PROGRAM PARTICIPATION AGREEMENT, Continued

Name and Address of Facility	Medicaid Provider Number

4. That it will give the Facility, (subject to Section A, Paragraph 17 herein), thirty (30) days notice of any impending changes in status as a participating Medical Day Care Facility; the Department may terminate this Agreement without cause following ninety (90) days advance, written notice to the Provider.

7. That it will notify the Facility of any change in Title XIX rules and regulations as it relates to the Facility's program, and will work with the individual Facility to provide the best care available within the limitations of the law and available money.

C. DEPARTMENT AND FACILITY MUTUALLY AGREE:

1. That, in the event the Federal and/or State laws should be amended or judicially interpreted so as to render the fulfillment of this agreement, on the part of either party, not feasible or impossible, or if the parties to this agreement should be unable to agree upon modifying amendments which would be needed to enable substantial continuation of the Title XIX Program as a result of amendments or judicial interpretations, then, and in that event, both the Facility and the Department shall be discharged from future obligations created under the terms of this agreement, except for equitable settlement of the respective accrued interests up to the date of termination.

2. That, in the event a participating Facility is sold, the Department shall make no division of the reimbursable proceeds for services rendered to Medicaid recipients between buyer and seller, but rather will reimburse the provider of record as of the billing month for all services rendered. Said Provider shall make the necessary adjustments.

3. This agreement shall be effective on _____ and will continue unless terminated or amended prior thereto:

   a. by mutual consent of the parties,

   b. for cause under applicable clauses herein, or

   c. because of Federal and/or State government withdrawal from Program participation.

4. To be completed by the Facility and the Department:

_____
Name of Authorized Representative of Facility (Print)

_____
(Title)

_____ _____
(Date) (Signature of Authorized Representative of Facility)

_____
(Name of Authorized Representative of NJDHSS (Print)

_____
(Title)

_____ _____
(Date) (Signature of Authorized Representative of NJDHSS)

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APPENDIX C

To Be Mailed with Medical Day Care Application Package

MEDICAL DAY CARE

Outline for Written Narrative Statement on Proposed Medical Day Care Center

1. Describe the philosophy, goals and objectives for providing medical and ancillary health services to a non-resident population on a day care basis.

2. Describe the physical facilities to be used for the proposed Medical Day Care Center (diagram acceptable).

3. Describe the proposed Medical Day Care Program, including hours of operation; services to be provided, in-hour and/or arrangement and staff who will be implementing the program.

4. Provide staff position descriptions and state qualifications of personnel selected for each position.

5. State total number of participants who will be served by Medical Day Care and give anticipated daily population.

6. Submit a projection of costs to be incurred by the Medical Day Care Program. State the period of projection, and provide the basis of cost allocation if applicable.

7. Will the Medical Day Care Center by funded by other than Title XIX; i.e., Title XX and Title III?

8. Is the proposed Medical Day Care Program a new service of your facility or an expansion of an existing Day Care program?

9. Additional comments relevant to the application for Medical Day Care under the New Jersey Medicaid Program.

APPENDIX D

State of New Jersey
Department of Health and Senior Services
Division of Consumer Support

MEDICAL DAY CARE ON-SITE REPORT

Name of Program _____ Survey Date _____
Address _____ Telephone Number _____
Facility Administrator _____ Initial Approval Date _____
Medical Day Care Center Director _____ Latest Contract Renewal Date_____
Current Total Enrollment _____
Avg. Daily Attendance _____ Medicaid Census _____
Number of Paid Staff _____ Number of Volunteers _____
(full-time)
Registered Nurse: Yes [ ] No [ ] Social Worker: Yes [ ] No [ ]
Activity Coordinator: Yes [ ] No [ ] Medical Director: Yes [ ] No [ ]
Check Each Item if Applicable:

Service Provided	Yes	No
1. Medical		
2. Nursing		
3. Social		
4. Transportation		
5. Personal Care		
6. Dietary		
7. Social Activities		
8. Rehabilitative Services		
9. Dental		
10. Podiatry		
Records		
11. Admission Form		
12. Individualized Plan or Care		
Updated Every 90 Days		
13. Initial Physical Exams		
Every 6 Months		
14. Medical Orders		
15. Current Lab Reports		
16. Nurses Notes		
Daily 1st 5 days		
Every 90 days		
17. Social History		
18. Social Progress Notes		
Every 90 days		

19. Initial Activity Plan	_____	_____
20. Activity Progress Notes	_____	_____
Every 90 days	_____	_____
21. Therapy Progress Notes	_____	_____
22. Discharge Plan	_____	_____
23. Emergency Provisions	_____	_____
24. Disaster Plan	_____	_____

Comments: Indicate deficient areas according to item number in preceding section.

_____
_____
_____
_____
_____

Team Recommendations to Facility:

_____
_____
_____
_____

Projected Revisit: _____

Facility Staff Present:

_____
_____
_____

_____
Medical Consultant

_____
RSN/RNS

_____
ASWS

APPENDIX E

State of New Jersey
Department of Health and Senior Services
Division of Consumer Support

Medicaid Participant Profile—Medical Day Care

1. _____ _____
Last Name First Name

2. _____
Participant's Street Address or Mailing Address

3. _____ 4. _____ 5. _____
City County Zip Code

6. __ / __ / ____ 7. _ 8. __ 9. __ 10. _
Month / Day / Year of Birth Sex Marital Status Race Veteran Status

11. _____ - __ 12. ___ - __ - ____
HSP (Medicaid) Case No. Social Security #

13. Waiver program? _ CCPED _ Model Waiver _ ACCAP _ N/A

13a. Level of care in waiver program __ (For Division Use Only)

13b. Attended day care before wavier? _ yes _ no

13c. If yes, how did participant pay? __ Other: _____

14. Living arrangement: __ Other: _____

15. Primary caregiver: __ Other: _____

16. Prior status: __ Other: _____

16a. If nursing home, give prior nursing home HSP# where different from current HSP#:
_____ - __ (For Division Use Only)

17. Primary diagnosis: _1 _2 _3 _4 _5 _6 _7 _8 _9 _10 _11 _12 _13 _14 _15 _16 _17 _18 _19 _20 _21 _22 _23 _24 _25 Other: _____

18. Secondary diagnoses: _1 _2 _3 _4 _5 _6 _7 _8 _9 _10 _11 _12 _13 _14 _15 _16 _17 _18 _19 _20 _21 _22 _23 _24 _25 Other: _____

19. Services required: _1 _2 _3 _4 _5 _6 _7 _8 _9 _10 _11 _12 _13 _14 _15 _16 _17 _18 _19 _20 _21 _22 Other: _____ _____

19a. If client is receiving therapies (service #s 1, 9 or 10 above), check payment mechanism:
_ Medicare _ Medicaid _ Private Insurance _ Other _____

19b. If the payor is private insurance, name carrer: _____

20. Enrollment: __ / __ / ____ (Month/Day/Year)

21. Reason for attendance: _1 _2 _3 _4 _5 _6 _7 _8 _9 _10 _11 _12 Other: _____

22. Source of referral: __ Other: _____

23. Maximum number of days/week approved by Medicaid: _

Center provider number: 3700 __ County of Provider: _____
Date: _____ Completed by: _____

State of New Jersey
Department of Health and Senior Services
Division of Consumer Support

Medicaid Participant Profile—Medical Day Care
Instructions for Participant Profile Sheet

PLEASE COMPLETE THIS FORM FOR MEDICAID PARTICIPANTS ONLY.

Please print all information, using blocks designated. Complete all applicable information. Print N/A in any blocks that are not applicable.

1. **Name**—Fill in last and first name. If name is longer than blocks allowed, fill in as much as possible.
2. **Participant's Street Address or Mailing Address**—Indicate as much of the street or mailing address as possible.
3. **City**—Indicate City of residence.
4. **County**—Indicate County of residence.
5. **Zip Code**—Indicate participant's zip code.
6. **Date of birth**—Indicate date of birth, giving month first, then day, then year.
7. **Sex**—Indicate M for male; F for female.
8. **Marital Status**—Indicate marital status by using appropriate code:
   01. Married
   02. Never Married
   03. Divorced
   04. Separated
   05. Widowed
9. **Race**—Indicate race by using appropriate code:
   01. American Indian
   02. Asian or Pacific Islander
   03. Black, Non-Hispanic Origin
   04. Hispanic
   05. White/Non-Hispanic
   06. Other
10. **Veteran Status:** Indicate Y for Yes, N for No.
11. **Medicaid HSP #**—Indicate the Medicaid Identification # assigned to the participant.
12. **Social Security #**—Indicate participant's own social security number.
13. **Waiver Program Participants**—Indicate if participant is in a Medicaid waiver program. Check the appropriate program, or N/A.

13a. The level of care assigned to the waiver program participant will be filled in by the Division of Medical Assistance and Health Services (Medicaid).

13b. Did participant attend Medical Day Care before acceptance into the waiver? Indicate yes or no.

13c. If participant was in medical day care before participation in a waiver program, how did the participant pay?
   01. Private pay
   02. Private insurance. Please write in name of provider on blank line.
   03. United Way
   04. Social Service Block Grants (Title XX)
   05. Older Americans Act (Title III)
   06. Scholarship from center
   07. Other. Specify.

14. **Living Arrangement**—Indicate the individual's living arrangement by using the appropriate code:
   01. Alone
   02. With parents or adult children
   03. With spouse
   04. With other relatives
   05. With non-relative
   06. Residential Home or Boarding Home or Rooming House or Supervised Apartments
   07. Foster Care
   08. Residential Health Care Facility
   09. Other (specify)

15. **Primary Caregiver**—Indicate who the primary caregiver is:
   01. Spouse
   02. Child
   03. Sibling
   04. Other relative
   05. Friend
   06. Neighbor
   07. Parent
   08. Foster Care
   09. None
   10. Boarding home sponsor in regular boarding home, or Supervisor of supervised apartments.
   11. Residential Health Care Facility.
   12. Other. Specify. (Includes attendant care.)

16. **Prior Status**—Indicate the location of the participant prior to enrolling in Medical Day Care
   01. In community (includes any non-residential facilities and boarding homes)
   02. In nursing home
   03. In-patient hospital

04. In-patient rehabilitation
05. Residential drug treatment center
06. Residential health care facility
07. Residential facility for mental retardation or mental illness
08. Other, specify.

16a. The prior nursing home HSP #, where applicable, will be supplied by Medicaid.

17. **Primary Diagnosis**—Indicate the one primary diagnosis for the participant at the point of entry into program, as stated by the attending physician. (Detailed explanations of diagnoses are attached.)
01. Musculoskeletal System and Connective Tissue Diseases
02. Fractures
03. Other Orthopedic
04. Diabetes
05. Anemia
06. Other Nutritional and Metabolic Diseases
07. Cancer
08. Cardiovascular
09. Cerebrovascular Accidents (Stroke)
10. Traumatic brain injuries
11. Hearing Impaired
12. Eye disorders
13. Cerebral Palsy
14. Multiple Sclerosis
15. Other Neurosensory
16. Alzheimer's and other Organic Brain Syndrome
17. Mental Illness
18. Mental Retardation
19. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)
20. Gastrointestinal
21. Alcoholism and Alcoholism Related Diseases
22. Genitourinary
23. Respiratory
24. Skin Diseases
25. General physical deterioration, frailty
26. Other (specify)_____

18. **Secondary Diagnoses:** Indicate the secondary diagnoses for the participant at the point of entry into the program, as stated by the attending physician. Check as many as are required, using the same list as for number 17.

19. **Services required**—Indicate the services required by the participant's plan of care. Check all that apply.
01. Physical Therapy and Rehabilitation
02. Respite Care
03. Assistance Shopping
04. Personal Care
05. Supervision/administration of Medications
06. Education in ADLs/IADLs
07. Socialization
08. Requires supervision during day
09. Speech therapy
10. Occupational Therapy (including sheltered workshops)
11. Reality Orientation
12. Therapeutic nutrition/nutritional education
13. Bowel and bladder training (or assistance with toileting)
14. Health monitoring
15. Skilled Nursing (direct care)
16. Psychotherapy/counseling/support groups
17. Therapeutic recreation
18. Case management and/or resource referrals
19. Foot care/podiatry
20. Transportation to doctor/therapies
21. Translator (to Spanish, sign language, etc.)
22. Other (specify)

19a. If client is receiving therapies (services #1, 9, or 10 above), check appropriate payment mechanism.

19b. If the payor is private insurance, name carrier.

20. **Date of Enrollment**—Indicate first date of attendance in Medical Day Care using numbers. (This would be the effective date on the prior authorization form FD-140).

21. **Reason for Attendance**—Indicate the most important reason(s) the participant attends Medical Day Care. Why does the client need the services you provide?
01. Recent deterioration of medical status
02. Loss of primary caregiver
03. Accident/Injury
04. Primary caregiver needs relief
05. Increased dependency in ADLs and IADLs
06. Caregiver employed outside home
07. Social isolation
08. Chronic physical health problems (includes "requires nursing daily")
09. Psychiatric problems or depression
10. Mental retardation
11. Disorientation or confusion
12. Other, specify.

22. **Source of referral.** Who contacted the center to refer the client?
01. Hospital (in or outpatient)
02. Doctor
03. Social Day Care Center or Psychiatric Day Treatment or Senior Center
04. Self

05. Family or Relative or Friends or Other client or boarding home operator or other primary caregiver
06. Nursing home
07. Home Health or Homemaker Agency
08. Social Service Agency or mental health agency or meals on wheels
09. Church or clergy
10. Medicaid District Office
11. Your center or any center staff member actively recruited
12. Other Medical Day Care Centers
13. Community Care Program for the Elderly and Disabled (CCPED)
14. Other state offices
15. Other (specify) _____

23. **Days in attendance:** Indicate the maximum number of days/week that were approved by the Medicaid District Office for the participant to attend, as of the participant's date of enrollment.

DIAGNOSES

01. Musculoskeletal System and Connective Tissue Diseases—Includes diseases such as arthritis, Rheumatoid and allied conditions, Osteomyelitis, other diseases of joints, and Lupus.

02. Fractures—Includes all fractures, simple or compound, long or shorter term, and joint replacements.

03. Other Orthopedic—Includes such diseases as scoliosis, dislocations, sprains, congenital deformities of the bones and organs of movement, traumatic and congenital amputations of limbs, except amputation due to diabetes.

04. Diabetes—Includes diabetes and its complications such as diabetic ulcer and amputation due to diabetes.

05. Anemia

06. Nutritional and Metabolic Diseases—Includes diseases such as Addison's disease, Cushing's disease, hypothyroidism, malnutrition and obesity, but not anemia or diabetes.

07. Cancer—Includes malignant neoplasms of all sites

08. Cardiovascular—Includes disease of the heart and blood vessels such as cardiovascular-renal diseases, hypertension, arteriosclerotic heart disease, congestive heart failures, pacemaker use and other heart diseases.

09. Cerebrovascular Accidents (Stroke)

10. Traumatic brain injuries—Includes traumas with resulting brain injury, such as aneurysm, lobotomy, gunshot wounds and car accidents, among others.

11. Hearing Impaired

12. Eye disorders—Cataracts, Glaucoma, blindness, etc.

13. Cerebral Palsy

14. Multiple sclerosis

15. Neurosensory—Includes diseases such as paraplegia, quadriplegia, hemiplegia, Parkinson's disease, epilepsy, ALS, neuralgia, seizure disorders, polio, spina bifida, and spinal cord injuries, among others.

16. Alzheimer's, Organic Brain Syndrome and other dementia.

17. Mental Illness—Includes all mental illness, such as schizophrenia and depression.

18. Mental retardation—mental retardation from whatever cause, including Downs Syndrome.

19. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)

20. Gastrointestinal—Includes all non-alcohol related gastrointestinal diseases, such as ulcers, hernias, gastritis, colitis, fecal impaction; and other diseases of the buccal cavity, esophagus, stomach, intestines, peritoneum, liver (except alcohol related cirrhosis), gall bladder and pancreas.

21. Alcoholism and Alcoholism related diseases (such as cirrhosis)

22. Genitourinary—Includes all genitourinary diseases, such as infections of the kidney, ureters, bladder and urethra; prostatitis, and other diseases of the prostate or male genital organs; diseases of the breast, ovaries, fallopian tubes and other female genital organs.

23. Respiratory—Includes all respiratory diseases, such as tuberculosis, COPD, emphysema, bronchitis, and pneumonia.

24. Skin Diseases

25. General physical deterioration, frailty

26. Other (specify)

APPENDIX F

Type of Contact: ☐ Phone ☐ At Agency ☐ Home

NEW JERSEY EASE COMPREHENSIVE ASSESSMENT TOOL

SECTION I - INFORMATION AND ASSISTANCE *(print all information)* Client ID#: _____
SSN #:

A. CLIENT IDENTIFICATION

Name: _____ DOB: _____ Sex: ☐ F ☐ M
(Last) (First) (M)

Address: _____
(Street) (Apt #) (City) (State) (Zip Code)

Mailing Address: _____

Phone/TTY: (____) _____ Alternate/Temporary Phone: (____) _____ County Code: ____

B. INITIAL CONTACT

Made by: ☐ Client ☐ Family Member_____ ☐ Service Provider ☐ Other_____
(specify) (specify)

Name: _____ Phone: (____) _____ ____

Address: _____ ☐ Anonymity Requested

Reason for Contact: _____

_____

_____

_____

Medical Diagnosis/Disability (only if relevant):_____

1. Is abuse, neglect or exploitation alleged? ☐ Yes, discuss with supervisor and go immediately to question 6.
☐ No, continue

2. A. Information/Services Requested / B. Material Provided / C. Currently Receiving: ☐ County Resource Directory Sent

A	B	C		A	B	C		A	B	C	
☐	☐	☐	a. Adult Day Services	☐	☐	☐	h. Housing	☐	☐	☐	o. Mental Health
☐	☐	☐	b. Adult Protective Services	☐	☐	☐	i. In-Home Services	☐	☐	☐	p. Nursing Facility
☐	☐	☐	c. Alternate Family Care	☐	☐	☐	j. Living Will/Adv.Dir.	☐	☐	☐	q Nutrition Programs
☐	☐	☐	d. Assisted Living	☐	☐	☐	k. Legal Services	☐	☐	☐	.. PAAD/Lifeline
☐	☐	☐	e. Crime Prevention	☐	☐	☐	l. Long Term Care Ins.	☐	☐	☐	s. SSI/Social Security
☐	☐	☐	f. Food Stamps	☐	☐	☐	m. Medicaid	☐	☐	☐	t. Transportation
☐	☐	☐	g. Health Ins./Managed Care	☐	☐	☐	n. Medicare	☐	☐	☐	u. Other _____

3. Is caller satisfied with information only? ☐ Yes ☐ No

4. Is further assessment of client required? ☐ Yes - Go to question 5. ☐ No - Contact is complete.

5. Is caller/client willing/able to provide additional data? ☐ Yes - Go to Benefits Screening on page 3.
☐ Home visit required - Complete Home Visit Section on page 11. ☐ No - Explain in notes on page 2.

6. If immediate referral is needed, specify agency, referral date, and contact person. _____

_____

_____ _____ _____
Name of Screener Signature of Screener Date

CLIENT NAME: _____ ID#: _____

CLIENT PROGRAM INCOME GUIDELINES

Race/Ethnicity: ☐ White ☐ Afr. Amer. ☐ Hispanic ☐ Natv. Amer. ☐ Asian ☐ Other ☐ Unknown
Client Status ☐ Frail ☐ Vulnerable

Income Level:	Single	Couple	Income Level:	Single	Couple
* 100% Poverty	☐	☐	* 200% Poverty	☐	☐
* 120% SSI	☐	☐	* 300% SSI	☐	☐
* 125% Poverty	☐	☐	* PAAD	☐	☐
* 150% Poverty	☐	☐	* Unknown	☐	☐

NOTES

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Type of Contact: ☐ Phone ☐ At Agency ☐ Home

CLIENT NAME: _____ ID#: _____

SECTION II - BENEFITS SCREENING

Source of Information: ☐ Client ☐ Client & Caregiver ☐ Caregiver Only ☐ Other, specify _____

Name: _____ Relationship: _____ Phone: _____

A. DEMOGRAPHICS

1. Client Address: _____ 2. Phone: _____
3. Marital Status: ☐ Married ☐ Widowed, How Long?_____ ☐ Separated ☐ Divorced ☐ Single ☐ Undisclosed
4. Name of Spouse: _____ 5. Veteran: ☐ Yes ☐ No 6. Spouse of a veteran: ☐ Yes ☐ No
7. Do you have children? ☐ Yes ☐ No 8. If yes, how many are living? _____ deceased? _____
9. Self-described racial background: ☐ White ☐ African American ☐ Native Indian, Eskimo, Aleut ☐ Hispanic ☐ Asian, Pacific Islander ☐ Unknown
10. Self-described Ethnic origin: _____ 11. Religion: _____
12. Education: ☐ Less than High School ☐ High School Graduate ☐ College Graduate ☐ Trade School ☐ Some High School ☐ Some College ☐ Graduate Degree ☐ Unknown
13. Employment Status: ☐ Employed full time ☐ Employed part time ☐ Unemployed ☐ Retired ☐ Other: _____
14. What kind of work did you do most of your life? _____
15. Do you want help seeking employment? ☐ Yes, make appropriate referral ☐ No, continue
16. Primary Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other (Specify): _____
17. Are you a U.S. citizen? ☐ Yes ☐ No 18. If not, what is your status? _____
19. How long have you lived in the U.S.? _____
20. Are you registered to vote? ☐ Yes ☐ No 21. Do you want information about voter registration? ☐ Yes ☐ No
22. Do you need an Absentee Ballot? ☐ Yes ☐ No

B. EMERGENCY CONTACT/PRIMARY CAREGIVER

1. Name: _____ Relationship: _____
   Address: _____ Phone: (H) _____ (W) _____
2. Name: _____ Relationship: _____
   Address: _____ Phone: (H) _____ (W) _____

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CLIENT NAME: _____ ID#: _____

3. Legal Representatives

Do you have any of the following?

Yes	No		Name	Check if Copy Obtained
☐	☐	Living Will/Advance Directive	_____	☐
☐	☐	Durable Power of Attorney for Health Care/Health Care Proxy	_____	☐
☐	☐	Representative Payee	_____	☐
☐	☐	Power of Attorney for Finances	_____	☐
☐	☐	Guardian	_____	☐
☐	☐	Conservator	_____	☐

C. PRIMARY HEALTH CARE PROVIDER

Name: _____ Address: _____ Phone: _____
(Names of other health care providers can be listed in the Professional Visits section on page 14.)

What type(s) of health insurance do you have? (Check all that apply. Include name of carrier and policy number.)

	Carrier	Policy #
☐ a. Dental	_____	_____
☐ b. Long Term Care	_____	_____
☐ c. Managed Care /HMO	_____	_____
☐ d. Medicaid	_____	_____
☐ e. Medicare	_____	_____
☐ f. Medicare Supplement	_____	_____
☐ g. Pending, specify	_____	_____
☐ h. Prescription	_____	_____
☐ i. Other, specify	_____	_____
☐ j. None	_____	_____

D. CURRENT FORMAL SERVICES

1. Do you currently participate in or receive or want any services, such as group meals, home care services, transportation etc.? ☐ Yes, Check all that apply. ☐ No, go to next section.

Receives	Wants	Provider/Frequency/Payment Source for received services
☐ a. Adult Day Services	☐	_____
☐ b. Adult Protective Services	☐	_____
☐ c. Alternate Family Care	☐	_____
☐ d. Assisted Living	☐	_____
☐ e. Assisted Transportation	☐	_____
☐ f. Care Management	☐	_____
☐ g. Chore/Home Repairs	☐	_____
☐ h. Congregate Meals/Senior Center	☐	_____
☐ i. Developmental Disability	☐	_____
☐ j. Friendly Visitor/Telephone Reassurance	☐	_____
☐ k. Financial Management/Counseling	☐	_____
☐ l. Home Care Services	☐	_____

CLIENT NAME: _____ ID#: _____

Receives	Wants	Provider/Frequency/Payment Source for received services
☐ m. Home Delivered Meals	☐	_____
☐ n. Housing	☐	_____
☐ o. Legal	☐	_____
☐ p. Mental Health	☐	_____
☐ q. Nutrition Counseling	☐	_____
☐ r. Personal Care	☐	_____
☐ s. Respite	☐	_____
☐ t. Substance Abuse Treatment	☐	_____
☐ u. Supported Employment	☐	_____
☐ v. Transportation	☐	_____
☐ w. Vocational Rehab/Job Counseling	☐	_____
☐ x. Other: _____	☐	_____

E. LIVING ARRANGEMENT/PHYSICAL ENVIRONMENT

1. Living Arrangement: (Check all that apply.)

	Name	Relationship
☐ a. Alone	_____	_____
☐ b. w/Spouse/Partner	_____	_____
☐ c. w/Non-relative(s)	_____	_____
☐ d. w/Other relative(s)	_____	_____
☐ e. w/Animal companion	_____	Type: _____

2. Residence Type: (Check all that apply.)

☐ a. House or Condominium
☐ b. Private Apartment
☐ c. Subsidized Housing _____
☐ d. Private Retirement Community _____
☐ e. Rented Room
☐ f. Mobile Home/Trailer
☐ g. Alternate Family Care
☐ h. Boarding Home
☐ i. Residential Health Care Facility
☐ j. Assisted Living (CPCH, ALP, ALR)
☐ k. Nursing Facility
☐ l. Other: _____

3. How do you heat your home? ☐ Gas ☐ Electric ☐ Oil ☐ Other, specify: _____

4. Are there problems with the physical environment? ☐ Yes, check and circle all that apply ☐ No, go to question 5 ☐ Licensed Residence, go to next section

A. Client/Family reported (Circle source of information) B. Worker observed

A	B		
☐	☐	a.	Inadequate lighting (e.g., indoors, outdoors)
☐	☐	b.	Faulty/inadequate wiring (e.g., exposed wires, overloaded extension cords)
☐	☐	c.	Flooring and carpeting (e.g., holes in the floor, electric wires where client walks, scatter rugs, oxygen tubing)
☐	☐	d.	Bathroom environment (e.g., inaccessible, non-operating toilet, leaking pipes, no rails, a slippery bathtub, outside toilet)
☐	☐	e.	Kitchen environment (e.g., inoperable/faulty/or missing major appliances, leaking pipes)
☐	☐	f.	Water (e.g., no running water, no hot water)
☐	☐	g.	Heating and cooling (e.g., too hot in summer, too cold in winter, no central heat)

CLIENT NAME: _____ **ID#:** _____

A B
- ☐ ☐ h. Personal safety (e.g., fear of violence, problems going to mailbox or visiting neighbors, heavy traffic in street)
- ☐ ☐ i. Access to house/room (e.g., unsafe stairs, missing handrails, handicapped inaccessible)
- ☐ ☐ j. Home accommodation (e.g., unable to accommodate therapeutic equipment/personnel)
- ☐ ☐ k. Insect/rodent infestation
- ☐ ☐ l. Fire hazards (e.g., lack of operable smoke alarm, excessive clutter)
- ☐ ☐ m. Other observed: _____

Comments: _____

5. Condition of living quarters observed during a home visit:

☐ a. Clean ☐ Yes ☐ No ☐ N/A
☐ b. Observable hazards ☐ Yes, answer question 6. ☐ No

6. If observable hazards, client's reaction to possible intervention:
Does client want intervention? ☐ Yes ☐ No ☐ N/A

F. FUNCTIONAL STATUS

1. How would you rate your (client's) overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2. Are you (the client) having any problems taking care of yourself, such as bathing or going to the bathroom?
☐ Yes, indicate level of functioning and if help is available for all that apply. ☐ No, go to question 3.

Activities of Daily Living (ADL) self-performed during the last seven days.

TASK	Client Reported Level	Help Available	Workers Observed Level	Level Codes
a. Eating				**0. INDEPENDENT:** No help or oversight required. A client is considered independent if he/she can use assistive devices without the assistance or supervision of another person.
b. Grooming/Personal Hygiene				
c. Bathing				**1. SUPERVISION:** Oversight, encouragement or cueing required.
d. Dressing				
e. Mobility in Bed				**2. LIMITED ASSISTANCE:** Requires physical help in maneuvering limbs or other non-weight bearing assistance.
f. Transferring				
g. Walking/Mobility				**3. EXTENSIVE ASSISTANCE:** Requires weight bearing support/transfer or full performance by another for part of the activity.
h. Stair climbing				
i. Toilet Use				**4. TOTAL DEPENDENCE:** Full activity done by another.

CLIENT NAME: _____ **ID#:** _____

3. Do you (the client) need help around the house, such as shopping or fixing a meal?
☐ Yes, indicate level of functioning and if help is available for all that apply. ☐ No, go to question 4.

Instrumental Activities of Daily Living (IADL) self-performed during the last seven days.

TASK	Client Reported Level	Help Available	Worker Observed Level	Level Codes
a. Meal Preparation				**0. INDEPENDENT:** No help or oversight required. A client is considered independent if he/she can use assistive devices without the assistance or supervision of another person.
b. Housekeeping				
c. Laundry				**1. DONE WITH HELP SOME OF THE TIME.**
d. Phone Use				
e. Shopping				**2. DONE WITH HELP ALL OF THE TIME.**
f. Transportation				**3. DONE BY OTHERS.**
g. Managing Money				
h. Managing Medications				**4. ACTIVITY DID NOT OCCUR.**
i. Home Maintenance				

4. Do you require assistive devices or special accommodations? ☐ Yes, comment ☐ No

Comments: _____

5. In the past year — Frequency/Dates

a. Have you fallen? ☐ Yes _____ ☐ No
b. Have you been admitted to a hospital? ☐ Yes _____ ☐ No
c. Have you gone to an emergency room? ☐ Yes _____ ☐ No

If yes to any of the above, explain: _____

G. SUPPORT SYSTEMS

1. Do any of your friends and/or relatives live near you? ☐ Yes ☐ No

2. How often do you see family, friends, or neighbors?
☐ Very often ☐ Occasionally ☐ Hardly at all ☐ Not at all

3. Do they give you any help? ☐ Yes ☐ No ☐ Don't need

Describe: _____

4. Are there any individuals who are dependent upon you for care and/or support? ☐ Yes ☐ No

If Yes, Name(s), Relationship(s) and Type of Care/Support: _____

CLIENT NAME: _____ **ID#:** _____

5. Do you live alone? ☐ Yes, skip to part H. ☐ No, go to question 6.

6. Do any of the people in your household work? ☐ Yes ☐ No

If Yes, Name(s) and Relationship(s): _____

_____

If no, does this person have another source of income? ☐ Yes ☐ No

H. FINANCES

1. Are you interested in services or benefits that require information about your finances?
   ☐ Yes, complete appropriate information below.
   ☐ No, go to the summary on page 11

2. What is your gross income? Monthly: _____ Annual: _____

3. What is the source(s)? (Check all that apply.)

	Amount		Amount
☐ a. Pension	_____	☐ g. Wages/Salary	_____
☐ b. Social Security Retirement	_____	☐ h. Municipal Assistance	_____
☐ c. Railroad Retirement	_____	☐ i. Reverse Mortgage	_____
☐ d. SSI	_____	☐ j. Other _____	_____
☐ e. SSDI	_____	Type _____	_____
☐ f. VA Benefits	_____	_____	_____

4. If married, what is your spouse's gross income? Monthly: _____ Annual: _____

5. What is the total gross household income? Monthly: _____ Annual: _____

6. Do you own your home? ☐ Yes ☐ No

7. Do you own other real estate? ☐ Yes ☐ No

8. Do you own a car? ☐ Yes ☐ No Make _____ Model _____ Year _____

9. What are the types and value of your assets such as stocks and bonds, excluding your house and car? _____

_____

10. Are there any liens against the assets? ☐ Yes ☐ No

If yes, specify: _____

_____

CLIENT NAME: _____ **ID#:** _____

11. Have you transferred any assets to other people within the past 36 months? ☐ Yes ☐ No

If yes, specify: _____

_____

12. Do you receive any benefits or entitlements? (Check all that apply.)

☐ a. Food Stamps
☐ b. Low Income Home Energy Assistance
☐ c. PAAD
☐ d. Other (Specify): _____

13. Expenses:

a. Does the amount of money you have take care of your needs? ☐ Yes, go to question 14. ☐ No, go to b.

b. Do you want to talk about your expenses? ☐ Yes, complete all that apply in C. ☐ No, go to question 14.

c. Monthly household expenses: please indicate the average dollar amount of each item listed below.

1. Rent/mortgage	_____	9. Credit cards	_____
2. Taxes	_____	10. Utilities	_____
3. Association/maintenance fees	_____	a) Gas/Electric	___/___
4. Transportation	_____	b) Oil	_____
5. Car	_____	c) Phone	_____
6. Insurance (life/home/car)	_____	d) Sewer/Water	___/___
7. Food/groceries	_____	e) Cable TV	_____
8. Loans	_____	11. Other_____	_____

d. Average monthly health expenses: please indicate the dollar amount of each item listed below.

1. Medications	_____	5. Hospital & lab fees	_____
2. Doctor visits	_____	6. Health insurance	_____
3. Home care	_____	7. Emergency response system	_____
4. Adult Day Services	_____	8. Other _____	_____

e. Comments: _____

14. Do you have life insurance? ☐ Yes ☐ No

Carrier _____ Policy Number _____ Face Value _____
Cash Value _____

15. Do you have a prepaid burial arrangement? ☐ Yes ☐ No

Funeral Home:_____ Address: _____ Phone:_____

CLIENT NAME: _____ ID#: _____

NOTES

CLIENT NAME: _____ ID#: _____

I. SUMMARY

1. **Home Visit Section**:

A. Home visit indicated? ☐ Yes ☐ No

B. Reason: _____

_____

C. Directions to Home

_____
_____
_____
_____
_____

D. Safety Issues Including Pets?

_____
_____
_____
_____
_____

E. Is Interpreter Needed? ☐ Yes (Specify): _____ ☐ No

2. **Benefit Screening Section Summary**:

A. Information/Services Requested / B. Material Provided: ☐ County Resource Directory Sent

A	B		A	B		A	B	
☐	☐	a. Adult Day Services	☐	☐	h. Housing	☐	☐	o. Mental Health
☐	☐	b. Adult Protective Services	☐	☐	i. In-Home Services	☐	☐	p. Nursing Facility
☐	☐	c. Alternate Family Care	☐	☐	j. Living Will/Adv. Dir.	☐	☐	q. Nutrition Programs
☐	☐	d. Assisted Living	☐	☐	k. Legal Services	☐	☐	r. PAAD/Lifeline
☐	☐	e. Crime Prevention	☐	☐	l. Long-Term Care Ins.	☐	☐	s. SSI/Social Security
☐	☐	f. Food Stamps	☐	☐	m. Medicaid	☐	☐	t. Transportation
☐	☐	g. Health Ins./Managed Care	☐	☐	n. Medicare	☐	☐	u. Other _____

3. **Referral Section:**

A.

Referral Date (Mo/Day/Year)	**Referral Made by**	**Services Referred for:**	**Service Provider**	**Contact Person**
__/__/__	_____	Extended Assessment	_____	_____
__/__/__	_____	Care Management	_____	_____
__/__/__	_____	Managed Care/HMO	_____	_____
__/__/__	_____	Pre-admission Screening	_____	_____
__/__/__	_____	Adult Protective Services	_____	_____
__/__/__	_____	Medicaid Application	_____	_____
__/__/__	_____	Other	_____	_____
__/__/__	_____	_____	_____	_____
__/__/__	_____	_____	_____	_____
__/__/__	_____	_____	_____	_____
__/__/__	_____	_____	_____	_____

B. 1. Does client/legal representative give release of information? ☐ Yes ☐ Verbal ☐ Written ☐ No

2. Any restriction? ☐ Yes, specify _____ ☐ No

3. Release of Information form sent? ☐ Yes ☐ No Date sent _____

C. Follow-up required within two weeks? ☐ Yes, date due _____ ☐ No

_____ Name of Screener

_____ Signature of Screener

_____ Date

CLIENT NAME: _____ ID#: _____

J. FOLLOW-UP OUTCOME

1. Client Follow-up:

   a. Release of Information form received? ☐ Yes, Date _____ ☐ No ☐N/A

   b. Date of contact: ___/___/___

	Yes	No		Yes	No
1. Client received literature	☐	☐	3. Client received services	☐	☐
2. Client called agency/services	☐	☐	If no, comment and go to No. 2.		
			4. Additional referral/services needed If yes, go to No. 3.	☐	☐

Comment: _____

_____

2. Agency Follow-up by Worker:

Date (Mo/Day/Year)	Provider Agency	Contact Person	Outcome
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____

3. Additional Referrals:

Referral Date	Referral Made By	Service Provider	Contact Person
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____

4. Continued follow-up needed? ☐ Yes ☐ No
   If yes, specify date, reason for follow-up, contact person. _____

_____

_____ _____ _____

Name of Follow-up Worker | Signature of Follow-up Worker | Date

K. QUALITY ASSURANCE

1. Record review ☐ Yes ☐ No Date: _____

2. Contact made:

	Phone	In-person	Mailed
☐ Client	☐	☐	☐
☐ Caregiver	☐	☐	☐
☐ Service Provider	☐	☐	☐
☐ Other (Specify): _____	☐	☐	☐

3. Comments: _____

_____

_____ _____ _____

Name of Quality Assurance Reviewer | Signature of Quality Assurance Reviewer | Date

CLIENT NAME: _____ ID#: _____

SECTION III - EXTENDED ASSESSMENT

SECTIONS OF THE EXTENDED ASSESSMENT THAT ARE TO BE USED SPECIFICALLY BY THE STATE'S LONG TERM CARE FIELD OFFICES OR THE NEW JERSEY EASE COUNTY AGENCIES ARE LABELED. ALL OTHER SECTIONS OF THIS ASSESSMENT ARE TO BE COMPLETED BY BOTH GROUPS.

Check all that apply as known to the patient, caregiver, or interviewer.

Complete any missing information in Information & Assistance and Benefit Screening Sections.
Source of Information: ☐ Client ☐ Client & Caregiver ☐ Caregiver Only ☐ Other, specify _____
Informant's Name: _____ Phone: _____ Relationship: _____
(If other than client)

A. PHYSICAL HEALTH ASSESSMENT - MEDICAL CONDITION/DIAGNOSES

QUESTION IN BOX IS FOR THE USE OF THE STATE'S LONG TERM CARE FIELD OFFICES.

1. Current or more detailed diagnosis and ICD-9 Codes.	
a.	| | | |●| |
b.	| | | |●| |
c.	| | | |●| |
d.	| | | |●| |

When the diagnosis is uncertain but a problem with a particular system is known to exist, check the appropriate category of disease, and leave the specific diagnosis box empty.

☐ 2. Heart/Circulation
- ☐ a. Heart Failure
- ☐ b. Coronary Artery Disease/Angina/ Heart Attack/Coronary Bypass
- ☐ c. Hypertension/High Blood Pressure
- ☐ d. Peripheral Vascular Disease/Claudication/ Limb Bypass

☐ 3. Skin
- ☐ a. Abrasion/Bruise
- ☐ b. Burn
- ☐ c. Rash
- ☐ d. Surgical Wound
- ☐ e. Pressure Ulcer
- ☐ f. Corn/Callous/Bunion
- ☐ g. Cellulitis
- ☐ h. Shingles

☐ 4. Neurological
- ☐ a. Alzheimer's Disease
- ☐ b. Non-Alzheimer's Dementia
- ☐ c. Stroke (CVA)
- ☐ d. Multiple Sclerosis
- ☐ e. Seizure Disorder
- ☐ f. Paraplegia/Hemiplegia/ Quadriplegia
- ☐ g. Traumatic Brain Injury
- ☐ h. Cerebral Palsy
- ☐ i. Transient Ischemic Attack (TIA)
- ☐ j. Parkinson's Disease

☐ 5. Endocrine/Metabolic
- ☐ a. Diabetes
- ☐ b. Hypothyroidism/Hyperthyroidism

☐ 6. Gastro-Intestinal
- ☐ a. Gastritis/gastric reflux
- ☐ b. Ulcer
- ☐ c. Hiatal hernia
- ☐ d. Diverticulitis
- ☐ e. Hepatitis/Cirrhosis/Pancreatitis
- ☐ f. Gall Bladder Disease

CLIENT NAME: _____ ID#: _____

☐ 7. Musculo-skeletal
- ☐ a. Arthritis or Rheumatic Disease
- ☐ b. Hip Fracture
- ☐ c. Other Bone Fracture
- ☐ d. Osteoporosis/Compression Fracture
- ☐ e. Amputation: Specify _____

☐ 8. Pulmonary
- ☐ a. Asthma
- ☐ b. Emphysema
- ☐ c. Pneumonia

☐ 9. Senses
- ☐ a. Cataract
- ☐ b. Glaucoma
- ☐ c. Macular Degeneration
- ☐ d. Diabetic Retinopathy
- ☐ e. Meniere's Disease
- ☐ f. Hearing Loss (Permanent)
- ☐ g. Cerumen Impaction

☐ 10. GU/GYN/Renal
- ☐ a. Prostate Problems
- ☐ b. Cystitis/Urethritis/Vaginitis
- ☐ c. Neurogenic Bladder
- ☐ d. Uterine Prolapse
- ☐ e. Sexual Dysfunction
- ☐ f. Urinary Tract Infection

☐ 11. Mental Health/Developmental Problems
- ☐ a. Anxiety Disorder
- ☐ b. Depression
- ☐ c. Personality Disorder
- ☐ d. Bipolar Disease (Manic Depressive Disorder)
- ☐ e. Schizophrenia
- ☐ f. Mental Retardation
- ☐ g. Down Syndrome

☐ 12. Other Disorders
- ☐ a. Anemia
- ☐ b. Cancer Specify Type/Site _____
- ☐ c. Allergies: Specify _____
- ☐ d. Substance Abuse: Specify _____
- ☐ e. Other Significant Illness: Specify: _____
- ☐ f. Pain: Specify _____
- ☐ g. Surgery: Specify _____

☐ 13. Infections
- ☐ a. HIV
- ☐ b. Vancomycin Resistant Enterococci (VRE)
- ☐ c. TB
- ☐ d. Methicillin Resistant Staph (MRSA)
- ☐ e. Clostridium Difficile (C. Diff)
- ☐ f. Conjunctivitis
- ☐ g. Septicemia

☐ 14. Immunizations Received
- ☐ a. Flu Date _____
- ☐ b Pneumonia Date _____
- ☐ c. Tetanus Date _____
- ☐ d. Hepatitis B Date _____

B. PHYSICAL HEALTH ASSESSMENT - PROFESSIONAL VISITS

1. Professional Visits:

In the past year have you seen a doctor or nurse practitioner, been admitted to a hospital or gone to an emergency room? ☐ a. Yes (complete below) ☐ b. No ☐ c. Don't Know

Provider	Telephone	Discharge Date	Reason for visit/admission

CLIENT NAME: _____ **ID#:** _____

2. Institutional Admissions:

Have you been a resident of a nursing facility, developmental center, psychiatric hospital, or a rehabilitation program for therapy, substance abuse, etc., in the past 5 years?

☐ a. Yes (complete below) ☐ b. No ☐ c. Don't Know

Year	Place	Reason	Program Completed Yes	Program Completed No
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐
_____	_____	_____	☐	☐

C. PHYSICAL HEALTH ASSESSMENT - MEDICATIONS

1. Are you allergic to any medications? ☐ Yes ☐ No Specify: _____

2. List all medications you take routinely (prescriptions, refrigerated medicines, include over the counter drugs such as aspirins, vitamins, laxatives, home remedies, etc.)

MEDICATION	DOSE	FREQUENCY	METHOD OF ADMINISTRATION	HEALTH CARE PROVIDER	PHARMACY
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					
i.					
j.					

3. Are any of the above medications outdated? ☐ Yes ☐ No Specify: _____

4. Do you take your medications as they are prescribed? ☐ Yes ☐ No Specify: _____

5. Do you have ONE health care provider with whom you discuss all your current medications?
☐ Yes ☐ No If yes, name of health care provider: _____

6. What method/reminder do you use to take your medications?
☐ a Caregiver gives them
☐ b. Client follows directions on label
☐ c. Written schedule/calendar
☐ d. Plastic pill minder
☐ e. Egg carton, envelopes
☐ f. Other (Specify): _____

CLIENT NAME: _____ ID#: _____

D. PSYCHO-SOCIAL ASSESSMENT

1. Cognitive Patterns:

How well does client make decisions about organizing the day (e.g., when to get up or have meals, which clothes to wear or activities to do)?

- ☐ 0. Independent - decisions consistently reasonable
- ☐ 1. Modified independence - some difficulty adjusting to new or unexpected situations
- ☐ 2. Moderately impaired - decisions poor; cues/supervision required
- ☐ 3. Severely impaired - never/rarely makes decisions

SCREENING TOOL IN BOX "2A." IS FOR THE USE OF THE NEW JERSEY EASE COUNTY AGENCIES

2A. Brief Mental Status Screening (Modified Kahn)

Purpose: Screening tool to be used to assess the client's short term and long term memory .

Introduction: "These questions ask about particular bits of information that many people forget from time to time. They are routine questions that may not apply to you directly. If it's okay, I'd like to be begin."

Only Errors are scored - Each error = 1

1. How old are you? (within 2 years) _____
2. In what year where you born? (exact year) _____
3. What year is it now? (exact year) _____
4. What month is it now? (If he/she doesn't know, ask the season) _____
5. What was your last meal? _____
6. What is your telephone number? _____
7. Count backwards from 10 to zero. (no errors permitted) _____
8. Where were you born? _____
9. What day of the week is it? _____
10. Who is the president now? (last name sufficient) _____

LEVEL OF MEMORY IMPAIRMENT _____

- ☐ a. No impairment (0 - 2 incorrect)
- ☐ b. Mild impairment (3 - 5 incorrect)
- ☐ c. Moderate impairment (6 - 8 incorrect)
- ☐ d. Severe impairment (9 - 10 incorrect)

TOTAL INCORRECT

QUESTIONS IN BOX "2B." ARE FOR THE USE OF THE STATE'S LONG TERM CARE FIELD OFFICES

2B. Record the individual's memory status

a. Short-term memory - seems/appears to recall after 5 minutes

0) Memory ok Code# _____
1) Memory problems

b. Long-term memory - seems/appears to recall long past

0) Memory ok Code# _____
1) Memory problems

CLIENT NAME: _____ **ID#:** _____

3. Behavior Patterns: Use the following codes to assess behavior problems outlined below.

a. Behavior Symptom Frequency Codes (Record the frequency at which the individual exhibits the behavior:)
0) Behavior not exhibited
1) Behavior occurs several times/month
2) Behavior occurs several times/week
3) Behavior occurs daily
4) Behavior occurs several times/day

b. Behavior Symptom Alterability Codes (Record the degree to which the behavior easily can be altered.)
0) Behavior not present or behavior easily altered
1) Behavior is not easily altered

Behavior Patterns: Refer to Code Guide above for appropriate coding	Code a	Code b
1) WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
2) VERBALLY ABUSIVE BEHAVIOR SYMPTOMS (others were threatened, screamed at, cursed at)		
3) PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
4) SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior, disrobing in public, smeared/threw food/feces, hoarding, rummaged through other's belongings)		
5) RESISTS CARE (resisted taking medications, injections, ADL assistance or eating)		

QUESTIONS IN BOX ARE FOR THE USE OF THE NEW JERSEY EASE COUNTY AGENCIES
(OPTIONAL FOR THE STATE'S LONG-TERM CARE FIELD OFFICES QUESTIONS 4-7)

4. Losses/Stressful Events:

1) Are any of the following currently affecting your life? (Check all that apply.)

☐ a. Change in work or employment
☐ b. Loss of a pet
☐ c. Financial problems
☐ d. A move or relocation
☐ e. Health problems
☐ f. Ability to drive
☐ g. Death of a spouse
☐ h. Death of someone close
☐ i. Family problems
☐ j. Major illness of someone close
☐ k. Crime
☐ l. Pain
☐ m. Fear
☐ n. Other: _____
☐ o. None of the above

2) If yes to any question above, please specify: _____

5. Sleep patterns:

a. Has there been any recent change in your sleep patterns? ☐ Yes ☐ No
If yes, specify _____

b. Usual Bedtime _____ Usual awakening _____

c. Do you use/need anything to help you sleep? ☐ Yes ☐ No
If yes, specify _____

d. Do you have any problems that interfere with your sleep? ☐ Yes ☐ No
If yes, specify _____

CLIENT NAME: _____ ID#: _____

QUESTIONS IN BOX ARE FOR THE USE OF THE NEW JERSEY EASE COUNTY AGENCIES
(OPTIONAL FOR THE STATE'S LONG-TERM CARE FIELD OFFICES QUESTIONS 4-7)

6. Depression Screener (D'Ath, Katona, & Mullan, 1994)
"Now I would like to ask a question about your mood over the past week. Just answer yes or no."
(If the client is not sure about his/her answer score the item as "yes").

   a. Do you feel that your life is empty? ☐ Yes ☐ No

   b. Assessor's Observations: ☐ Client obviously and manifestly depressed (cries and expresses hopelessness)
   ☐ Some signs of depression evident on interview (looks sad)
   ☐ No signs of depression noted

7. Suicide Screening

   a. Have you withdrawn from people and/or activities you used to enjoy? ☐ Yes ☐ No

   b. Have you ever thought about suicide? ☐ Yes ☐ No, go on to question 8
      1) If yes, are you thinking about suicide now? ☐ Yes ☐ No
      2) If yes, do you have a plan? ☐ Yes ☐ No

If client answers yes to questions 7b.1. or 7b.2. make an immediate referral to appropriate local mental heath agency.

8. Social Functioning

   a. Is religion currently a part of your life? ☐ Yes ☐ No

      1) Do you attend religious activities? ☐ Yes ☐ No, go to question 2.
      If yes, specify a congregation and contact person: _____

      2) Would you like to attend religious activities? ☐ Yes ☐ No

   b. Do you participate in planned or organized activities? ☐ Yes ☐ No

      1) If yes, list: _____

      2) If no, would you like to participate in activities? ☐ Yes ☐ No

   c. Do you perform any volunteer activities? ☐ Yes ☐ No

      If yes, specify: _____

   d. How do you spend your leisure time? _____

      _____

   e. Are you satisfied with your current activities? ☐ Yes ☐ No

      If no, explain: _____

   f. Do you have a warm close relationship with another individual? ☐ Yes ☐ No

      Comments: _____

CLIENT NAME: _____ ID#: _____

E. PHYSICAL HEALTH ASSESSMENT - PHYSICAL FUNCTIONING

ASSESSMENT QUESTIONS IN BOX "1." ARE FOR THE USE OF THE STATE'S LONG TERM CARE FIELD OFFICES

1.	**ADL SELF-PERFORMANCE**--The following address the client's physical functioning in routine personal activities of daily living for example, dressing, eating, etc. Code client's capacity for ADL self-performance, using the codes listed below. For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity. 0. INDEPENDENT--No help or oversight. 1. SUPERVISION--Oversight, encouragement or cueing. 2. LIMITED ASSISTANCE--Client highly involved in activity; received physical help in guiding maneuvering of limbs or other non-weight bearing assistance. 3. EXTENSIVE ASSISTANCE--While client performed part of activity, help of following type(s) were provided: Weight bearing support--OR--Full performance by another during part (but not all) of activity. 4. TOTAL DEPENDENCE--Full performance of activity by another.		CODE
a.	MOBILITY IN BED	Including moving to and from lying position, turning side to side and positioning body while in bed.	
b.	TRANSFER	Including moving to and between surfaces--to/from bed, chair, wheelchair, standing position. (Note--Excludes to/from bath/toilet).	
c.	LOCOMOTION IN HOME	(Note--if in wheelchair, self-sufficiency once in chair)	
d.	DRESSING	Including laying out clothes, retrieving clothes from closet, putting clothes on and taking clothes off.	
e.	EATING	Including taking in food by any method, including tube feedings.	
f.	TOILET USE	Including using the toilet room or commode, bedpan, urinal, transferring on/off toilet, cleaning self after toilet use, changing pad, managing any special devices required (ostomy or catheter), and adjusting clothes.	
g.	PERSONAL HYGIENE	Including combing hair, brushing teeth, shaving, applying make up, washing/drying face and hands, and perineum (Exclude baths and showers)	
h.	BATHING	How client bathed (including shower, full tub or sponge both; excluding washing back or hair) 0. Independent , did on own 1. Supervision ---oversight help only 2. Received assistance in transfer only 3. Received assistance in part of bathing activity 4. Total dependence	
i.	PRIMARY MODES OF LOCOMOTION	0. No assistive devices 1. Cane 2. Walker/crutch 3. Scooter (e.g., Amigo) 4. Wheelchair	a.
		a. Indoors b. Outdoors	b.
j.	STAIR CLIMBING	How client went up and down stairs (e.g., single or multiple steps, using handrail as needed). If client did not go up and down stairs, code client's capacity for stair climbing. 0. Up and down stairs without help 1. Up and down stairs with help 2. Does not go up and down stairs-could do without help 3. Does not go up and down stairs--could do with help 4. Does not go up and down stairs--no capacity to do it	
k.	NIGHT TIME CARE NEEDS	What care does the client require at night, include toileting needs, wandering precautions, positioning, medications, incontinence care, wake periods, dressing changes or other treatments. Code using: 0. No assistance required 1. Oversight required 2. Limited assistance required 3. Extensive assistance required 4. Total dependence	

CLIENT NAME: _____ ID#: _____

ASSESSMENT QUESTIONS IN BOX "2." ARE FOR THE USE OF THE STATE'S LONG TERM CARE FIELD OFFICES

2. IADL SELF-PERFORMANCE--Code for client capacity for self-performance in routine activities around the home or in the community.

(A) IADL SELF- PERFORMANCE CODE
0. INDEPENDENT--did on own
1. SOME HELP--help some of the time
2. FULL HELP--- performed with help all of the time
3. BY OTHERS--performed by others

(B) IADL DIFFICULTY CODE-- How difficult it is (or would it be) for client to do activity on own
0. NO DIFFICULTY
1. SOME DIFFICULTY--e.g., needs some help, is very slow, or fatigues
2. GREAT DIFFICULTY--e.g., little or no involvement in activity is possible

			Performance Difficulty (A)	(B)
a.	MEAL PREPARATION	How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food and utensils).		
b.	ORDINARY HOUSEWORK	How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)		
c.	MANAGING FINANCE	How bills are paid, checkbook is balanced, household expenses are balanced.		
d.	MANAGING MEDICATIONS	How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, giving injections, applying ointments).		
e.	PHONE USE	How telephone calls are made or receive (with assistive devices such as large number on telephone, amplification as needed).		
f.	SHOPPING	How shopping is performed for food and household items (e.g., selecting items, managing money).		
g.	TRANSPORTATION	How client travels by vehicle (e.g., gets to places beyond walking distance).		

3. Bladder Continence (Code continence with ostomy)
Record appropriate Code # _____

0. Continent - complete control
1. Usually continent - incontinence episodes once a week or less
2. Occasionally incontinent - 2+ times/week but not daily
3. Frequently incontinent - tends to be incontinent daily, but some control present
4. Incontinent - inadequate control, multiple daily episodes

4. Bowel Continence (Code continence with ostomy)
Record appropriate Code # _____

0. Continent - complete control
1. Usually continent - incontinence episodes once a week or less
2. Occasionally incontinent - once a week
3. Frequently incontinent - 2 to 3 times/week
4. Incontinent - inadequate control, multiple daily episodes

5. Bladder/Bowel Devices
For each Bladder/Bowel Device record whether person is:
Independent in use - Code = 0 Needs assistance - Code = 1 Not used - Code = 5

a. Pads and briefs _____
b. External (condom) catheter _____
c. Indwelling catheter _____
d. Ostomy _____
e. Intermittent catheterization _____

CLIENT NAME: _____ ID#: _____

F. PHYSICAL HEALTH ASSESSMENT - COMMUNICATION/HEARING/VISION

QUESTIONS ARE FOR THE USE OF THE NEW JERSEY EASE COUNTY AGENCIES
(OPTIONAL FOR THE STATE'S LONG-TERM CARE FIELD OFFICES)

1. Communication Techniques/Devices (record all appropriate code#(s) that apply) _____

   0. Hearing aid, present and used
   1. Hearing aid, present and not used regularly
   2. Other communication techniques/devices used (e.g., lip reading) Specify: _____
   3. None of the above

2. Hearing (record ability code # with hearing appliance, if used) _____

   0. Hears adequately-normal talk, TV, phone
   1. Some difficulty when not in quiet setting
   2. Hears in special situations only-speaker has to adjust tonal quality and speak distinctly
   3. Highly impaired-absence of useful hearing

3. Visual appliances (record all appropriate code#(s) that apply) _____

   0. Glasses
   1. Contact lens
   2. Magnifying glass
   3. Low vision devices
   4. None of the above

4. Vision (record ability code # to see in adequate light and with glasses if used) _____

   0. Adequate-sees fine detail, including regular print in newspapers/books
   1. Impaired-sees large print but not regular print in newspapers/books
   2. Moderately impaired-limited vision; not able to see newspaper headlines, but can identify objects
   3. Highly impaired-object identification in question, but eyes appear to follow objects
   4. Severely impaired-no vision or sees only light, colors, or shapes; eyes do not appear to follow objects

5. Making self understood (record ability code # of however person is able) _____

   0. Understood
   1. Usually understood-difficulty finding words or finishing thoughts
   2. Sometimes understood-ability is limited to making concrete requests
   3. Rarely/Never understood

6. Ability to understand others (record ability code #) _____

   0. Understands
   1. Usually understands-may miss some part/intent of message
   2. Sometimes understands - responds adequately to simple, direct communication
   3. Rarely/Never understands

CLIENT NAME: _____ ID#: _____

G. PHYSICAL HEALTH ASSESSMENT - NUTRITION STATUS AND LIFESTYLE

QUESTIONS ARE FOR THE USE OF THE NEW JERSEY EASE COUNTY AGENCIES
(OPTIONAL FOR THE STATE'S LONG-TERM CARE FIELD OFFICES)

Some of the questions in this section have values assigned to their yes answers. Answer all the following questions, add up the values of those questions that have a yes response, and recorded the final score in item 20.

1. How tall are you? (ft./in.): _____

2. How much do you weigh? (lbs): _____

3. Is this your normal weight? ☐ Yes ☐ No

4 a. Have you lost 10 pounds in the last six months without wanting to? ☐ Yes (2) ☐ No

b. Have you gained 10 pounds in the last six months without wanting to? ☐ Yes (2) ☐ No

5. Are you on any special diet(s)? ☐ Yes ☐ No

Check all that apply:
☐ a. Low Fat/Cholesterol
☐ b. No/Low Salt
☐ c. No/Low Sugar/ Diabetic
☐ d. Other, specify: _____

6. Do you take dietary supplements, e.g., Ensure? ☐ Yes ☐ No

Check all that apply:
☐ a. Occasionally
☐ b. Daily, Not Primary Source of Nutrition
☐ c. Daily, Sole Source of Nutrition
☐ d. Other, specify: _____

7. Do you have any problems that make it hard to eat? ☐ Yes (2) ☐ No

Check all that apply:	**Explain**
☐ a. Food Allergies	_____
☐ b. Nausea/Vomiting/Diarrhea	_____
☐ c. Problems Eating Certain Foods	_____
☐ d. Problems Following Certain Diets	_____
☐ e. Problems Swallowing or Chewing	_____
☐ f. Taste Problems	_____
☐ g. Tooth or Mouth Problems	_____
☐ h. Mouth is Dry When Eating A Meal	_____
☐ i. Other: _____	

	Yes	**No**
8. Has a health problem/condition made you change the kind and/or amount of food eaten? Specify: _____	☐ (2)	☐
9. Do you eat fewer than 2 meals per day?	☐ (3)	☐
10. Do you eat less than 5 vegetables or fruits per day?	☐ (1)	☐
11. Do you use milk or milk products every day?	☐ (1)	☐

		Yes	No
12.	Do you have 3 or more drinks of beer, liquor or wine almost every day?	☐ (2)	☐
13.	How many drinks do you consume in a day? _____		
14.	Do you sometimes not have enough money to buy food?	☐ (4)	☐
15.	Do you eat alone most of the time?	☐ (1)	☐
16.	Are you usually able to shop, cook, and/or feed yourself?	☐ (2)	☐
17.	Do you smoke or chew tobacco regularly?	☐ (1)	☐
18.	Do you take 3 or more different prescribed or over the counter per day?	☐ (1)	☐
19.	Do you have tooth or mouth problems that make it hard of you to eat?	☐ (2)	☐
20.	Nutritional Risk Level according to the following scores • _____ a. Good (0-2) • _____ b. Moderate (3-5) • _____ C. High Risk	Total Score _____ (6+)	
21.	Site of Nutrition Assessment _____ Date _____		
22.	Name of Nutrition Assessor _____ Title _____		
23.	Identify program/service that this Nutritional Assessment was conducted for		

Additional comments: _____

_____

H. PHYSICAL HEALTH ASSESSMENT - SPECIAL TREATMENTS AND PROCEDURES/ASSISTIVE DEVICES/EQUIPMENT

ASSESSMENT QUESTIONS IN BOX "1." ARE FOR THE USE OF THE STATE'S LONG TERM CARE FIELD OFFICES

1. Nursing Rehabilitation Restorative Care:

Record the following rehabilitation or restorative techniques or practices that were provided to the client for more than or equal to 15 minutes per day in Column A. Record the rehabilitative or restorative techniques that the client needs in Column B. (Enter 0 if none or less than 15 minutes per day.)

	A	B		A	B
a. Range of motion - passive	_____	_____	g. Dressing or grooming	_____	_____
b. Range of motion - active	_____	_____	h. Eating or swallowing	_____	_____
c. Splint or brace assistance	_____	_____	i. Amputation/prosthesis care	_____	_____
d. Bed mobility	_____	_____	j. Communication	_____	_____
e. Transfer	_____	_____	k. Reality Orientation	_____	_____
f. Walking	_____	_____	l. Other, specify	_____	_____

CLIENT NAME: _____ **ID#:** _____

2. Rehabilitative Therapies:

Have you received or are you currently receiving any of the following rehabilitative therapies?

	Yes	No	When	Need: Yes	Need: No
a. Speech - language pathology and audiology services	☐	☐	_____	☐	☐
b. Occupational therapy	☐	☐	_____	☐	☐
c. Physical therapy	☐	☐	_____	☐	☐
d. Respiratory therapy	☐	☐	_____	☐	☐
e. Psychological therapy (by licensed mental health professional)	☐	☐	_____	☐	☐
f. Cognitive/Remotivation therapy	☐	☐	_____	☐	☐
g. Alcohol/Drug Treatment Program	☐	☐	_____	☐	☐
h. Behavior Management	☐	☐	_____	☐	☐
i. Other (Specify): _____	☐	☐	_____	☐	☐

3. Do you currently use or need any of the following?

Check all that apply:

Use	Need	
☐	☐	a. Walker/Crutch
☐	☐	b. Cane
☐	☐	c. Wheelchair/Transfer Equipment
☐	☐	d. Splint/Brace/Prosthesis
☐	☐	e. Hearing Aid
☐	☐	f. Glasses
☐	☐	g. Dentures
☐	☐	h. Hospital Bed

Check all that apply:

Use	Need	
☐	☐	i. Incontinence Pads
☐	☐	j. Commode
☐	☐	k. Adaptive Eating Equipment
☐	☐	l. Shower Chair
☐	☐	m. Elevated Toilet Seat
☐	☐	n. Grab Bars
☐	☐	o. Amplifier For Phone
☐	☐	p. Other: Specify _____
☐	☐	q. None of Above

4. Are you currently receiving any of the following? Check all that apply in Column A.

5. Does the client need any of the following? Check all that apply in Column B.

Check all that apply:

A	B		
☐	☐	a.	Chemotherapy
☐	☐	b.	Dialysis - Renal
☐	☐	c.	Dialysis - Peritoneal (CAPD)
☐	☐	d.	IV Therapy/Hyperalimentation*
☐	☐	e.	Intake/Output
☐	☐	f.	Monitoring Medical Condition
☐	☐	g.	Ostomy Care
☐	☐	h.	Oxygen Therapy*
☐	☐	i.	Radiation
☐	☐	j.	Suctioning
☐	☐	k.	Tracheostomy Care*
☐	☐	l.	Ventilator or Respirator*
☐	☐	m.	Transfusions
☐	☐	n.	Hospice Care
☐	☐	o.	Wound Care
☐	☐	p.	Bowel/Bladder Training
☐	☐	q.	Pain Management Program
☐	☐	r.	Continuous Positive Airway Pressure (CPAP)

A	B		
☐	☐	s.	Bilevel Positive Airway Pressure (BiPAP)
☐	☐	t.	Medication by Injection
☐	☐	u.	Nasogastric/G-tube Feeding*
☐	☐	v.	Head Trauma/Adv. Neuro* Muscular/Orthopedic Care
☐	☐	w.	External (Condom) Catheter
☐	☐	x.	Indwelling Urinary Catheter
☐	☐	y.	Glucose Monitoring
☐	☐	z.	Laboratory Tests to Monitor/Adjust Medication/Treatment Regime
☐	☐	aa.	Intermittent Catherization
☐	☐	bb.	Routine Cast Care
☐	☐	cc.	Pacemaker/EKG Checks
☐	☐	dd.	Other _____
☐	☐	ee.	None of the Above

*See Appendix A in the User's Manual for The New Jersey EASE Comprehensive Assessment Instrument for Medicaid Program definitions (N.J.A.C. 10:63-2.2)

CLIENT NAME: _____ **ID#:** _____

I. CAREGIVER'S INTERVIEW

1. Does client have a family helper or other informal/unpaid source of help for personal care, e.g. bathing, feeding, dressing? ☐ Yes ☐ No
   If yes, specify whom _____
2. Does client have a family helper or other informal/unpaid source of help for other activities e.g. meal preparation, shopping, transportation, medications ? ☐ Yes ☐ No
   If yes, specify whom _____

DIRECTIONS FOR THE STATE'S LONG TERM CARE FIELD OFFICE STAFF:

If response to question 1 and 2 is no, or if client is in a licensed residence and has no potential for community placement, go to HSDP.

If response to question 1 or 2 is yes, and client has potential for community placement, go to question 3.

Questions 3-9 must be answered by the individual listed as Primary Caregiver on Page 3, Section B #2.

3. On average how many **hours per day** of hands on care does the client need?
   a. On average how many hours of this care are provided by paid caregiver?
      ☐ 0 hrs. ☐ 1-4 hrs. ☐ 5-8 hrs. ☐ more than 8 hrs.
   b. On average how many hours of this care are provided by unpaid caregiver?
      ☐ 0 hrs. ☐ 1-4 hrs. ☐ 5-8 hrs. ☐ more than 8 hrs.
4. On average how many **hours per week** does client need help with other activities such as meal preparation, shopping, medications and transportation?
   ☐ 0 hrs. ☐ 1-7 hrs. ☐ 8-15 hrs. ☐ more than 15 hrs.
5. How many **hours per day** can the client be left alone?
   ☐ 0 hrs. ☐ 1-4 hrs. ☐ 5-8 hrs. ☐ more than 8 hrs.
6. Do any of the following issues make it difficult for you to provide care for the client?
   a. Health problems ☐ Yes ☐ No
      If yes, specify _____
   b. Family responsibilities ☐ Yes ☐ No
      If yes, specify _____
   c. Financial problems ☐ Yes ☐ No
      If yes, specify _____
   d Employment ☐ Yes ☐ No
      If yes, specify _____
   e. Proximity to client ☐ Yes ☐ No
      If yes, specify _____
   f. Knowledge and skill needed ☐ Yes ☐ No
      If yes, specify _____
   g. Access to health ~~care providers~~ ☐ Yes ☐ No
      If yes, specify _____
   h. Family conflicts ☐ Yes ☐ No
      If yes, specify _____

7. Would you say caregiving gives you a sense of satisfaction? ☐ Yes ☐ No

8. Would you say caregiving strains your sense of well being? ☐ Yes ☐ No

9. If the client requires someone to accept 24-hour responsibility for the client's health and welfare in the community, will you accept this responsibility? ☐ Yes ☐ No ☐ Not applicable

Comments: _____

NOTES

CLIENT NAME: _____ ID#: _____

J. ASSESSMENT SUMMARY

Check all that apply	ASSESSED NEEDS/SERVICES	SERVICE PROVIDER/ CONTACT	TO BE CONTACTED BY: (1) NJ EASE (2) CLIENT (3) CAREGIVER
	Adaptations: Home, vehicle		
	Adult Day Services: Medical or social		
	Care Management: Obtain information, coordinate services, ongoing evaluation and modification of service (care) plan		
	Comprehensive Multidisciplinary Assessment		
	Entitlement Programs		
	Financial Management: Help with money management, banking activity, bill paying		
	Family Support: Counseling, training, support groups		
	Home Health Services: Nursing, home health aide/homemaker		
	Home Maintenance: Yard work, snow removal, home repair, other chore work		
	Housing: Independent, supportive, institutional		
	Housekeeping: Light cleaning services		
	Hospice		
	Independent Living Skills: Self-care, communication skills, socialization, mobility, sensory/motor development, community living		
	Legal		

CLIENT NAME: _____ ID#: _____

Check all that apply	ASSESSED NEEDS/SERVICES	SERVICE PROVIDER/ CONTACT	TO BE CONTACTED BY: (1) NJ EASE (2) CLIENT (3) CAREGIVER
	Medicaid NF Assessment		
	Medications: Set up, supervise, teach and review, evaluate and report to physician, administer		
	Mental Health Services: Screening, individual and/or group counseling		
	Nutrition Services: Congregate/ home delivered meals/nutrition counseling		
	Personal Care Assistant Services: Bathing, toileting, grooming, walking, transferring, wheeling, eating, dressing, shopping, errands		
	Protective Services: Investigation, case management for vulnerable adults who are abused/neglected/exploited		
	Primary Care Provider: Physician, nurse practitioner, clinic		
	Rehabilitative Services: Physical therapy, speech therapy, occupational therapy, recreational therapy, etc.		
	Respite Care: Intermittent or regular substitute for the caregiver		
	Social Services: Information and referral, counseling, advocacy		
	Supervision of Person: 24 hour supervision and/or monitoring of person		
	Supplies/Equipment: Assistive devices and emergency response system devices		
	Transportation: Medical, personal, social		
	Other:		

Is client willing to accept all services checked above? ☐ Yes ☐ No
If no, explain in Section K.