

**CHAPTER 3**

**OFFICE OF THE OMBUDSPERSON FOR THE INSTITUTIONALIZED ELDERLY PRACTICE AND PROCEDURE RULES**

**Authority**

N.J.S.A. 26:2H-53 et seq., 52:27EE-1 et seq., specifically 52:27EE-5(d) and 52:27EE-65, and 52:27G-1 et seq.; and Reorganization Plan 001-1996.

**Source and Effective Date**

R.2007 d.366, effective October 29, 2007.  
See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

**Chapter Expiration Date**

In accordance with N.J.S.A. 52:14B-5.1.c(2), Chapter 3, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, expires on April 27, 2015. See: 46 N.J.R. 2336(a).

**Chapter Historical Note**

Chapter 90, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, was originally codified in Title 5 as Chapter 100, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules. Chapter 100, Ombudsman Practice and Procedure and Public Notice Requirements, was adopted as R.1979 d.166, effective May 1, 1979. See: 11 N.J.R. 164(b), 11 N.J.R. 274(a).

Pursuant to Executive Order No. 66(1978), Chapter 100, Ombudsman Practice and Procedure and Public Notice Requirements, was readopted as R.1989 d.295, effective May 5, 1989. See: 21 N.J.R. 368(a), 21 N.J.R. 1516(b).

Chapter 100, Ombudsman Practice and Procedure and Public Notice Requirements, was repealed, and Chapter 100, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, was adopted as new rules by R.1990 d.316, effective June 18, 1990. See: 22 N.J.R. 1016(c), 22 N.J.R. 1926(a).

Pursuant to Executive Order No. 66(1978), Chapter 100, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, was readopted as R.1995 d.336, effective May 26, 1995. See: 27 N.J.R. 1348(a), 27 N.J.R. 2388(a).

Pursuant to Reorganization Plan No. 001-1996, Chapter 100, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, was recodified as N.J.A.C. 8:90, effective October 15, 1997. See: 29 N.J.R. 4679(a). Pursuant to Executive Order No. 66(1978), Chapter 90, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, expired on May 26, 2000.

Chapter 90, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, was adopted as new rules by R.2002 d.35, effective February 4, 2002. See: 33 N.J.R. 2762(b), 33 N.J.R. 3280(a), 34 N.J.R. 735(a).

In accordance with N.J.S.A. 52:14B-5.1d, the expiration date of Chapter 90, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, was extended by gubernatorial directive from February 4, 2007 to May 4, 2007. See: 39 N.J.R. 772(a).

Chapter 3, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, was recodified from N.J.A.C. 8:90 by R.2007 d.366, and was renamed Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, effective December 3, 2007. See: Source and Effective Date. See, also, section annotations.

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 3, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, was scheduled to expire on October 29, 2014. See: 43 N.J.R. 1203(a).

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**SUBCHAPTER 1. GENERAL PROVISIONS**

**15A:3-1.1 Scope**

The basic objective of the Office of the Ombudsman for the Institutionalized Elderly is of promoting, advocating and ensuring, as a whole and in particular cases, the adequacy of the care received, and the quality of life experienced, by elderly patients, residents and clients of facilities offering health or health-related services for the institutionalized elderly within New Jersey. The Office of the Ombudsman advocates for the health, safety and welfare, and the civil and human rights of the institutionalized elderly, age 60 or over, and takes such actions as are necessary, and within its jurisdiction, to secure same.

Recodified from N.J.A.C. 8:90-1.1 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).  
Substituted "Ombudsman" for "Ombudsman" two times.

**15A:3-1.2 Definitions**

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

"Abuse" means the willful infliction of physical pain, injury or mental anguish; unreasonable confinement; or the

willful deprivation of services which are necessary to maintain a resident's physical and mental health. "Abuse" shall also mean imposing treatment upon a resident who has the capacity to make healthcare decisions, after the resident has made a voluntary and informed choice regarding such treatment. "Abuse" shall also mean providing to a resident treatment that is not medically indicated. However, no resident shall be deemed to be abused for the sole reason that he or she is being furnished non-medical remedial treatment by spiritual means through prayer alone, in accordance with a recognized religious method of healing, in lieu of medical treatment, if it is shown through the Office's review that the resident subscribes to such religious method of healing. "Abuse" also shall not mean the withholding or withdrawal of life-sustaining treatment in accordance with the provisions of N.J.A.C. 15A:3-2.

An "act" of any facility or government agency shall be deemed to include any failure or refusal to act by such facility or government agency.

"Administrator" means any person who is charged with the general administration or supervision of a facility, whether or not such person has an ownership interest in such facility, and whether or not such person's functions and duties are shared with one or more other persons.

"Caregiver" or "caretaker" means a person employed or contracted to provide care or services to an elderly person, and includes, but is not limited to, the administrator of a facility.

"Exploitation" means the act or process of using a person or his or her resources for another person's profit or advantage without legal entitlement to do so.

"Facility" means any facility or institution, whether public or private, offering health or health-related services for the institutionalized elderly, and which is subject to regulation, visitation, inspection, or supervision by any government agency. Facilities include, but are not limited to, nursing homes, skilled nursing homes, intermediate care facilities, extended care facilities, convalescent homes, rehabilitation centers, assisted living facilities, residences and programs, residential healthcare facilities, comprehensive personal care homes, special hospitals, veterans' hospitals, chronic disease hospitals, psychiatric hospitals, mental hospitals, mental retardation centers or facilities, day care facilities for the elderly, medical day care centers, and adult family care homes. "Facility" shall not mean a correctional facility or an acute care medical center but shall include a rehabilitation facility housed within an acute care medical center.

"Government agency" means any department, division, office, bureau, board, commission, authority, or any other agency or instrumentality created by the State or to which the State is a party, or by any county or municipality, which is responsible for the regulation, visitation, inspection or supervision of facilities, or which provides services to patients, residents or clients of facilities.

"Institutionalized elderly," "elderly" or "elderly person" means any person 60 years of age or older, who is a patient, resident or client of any facility.

"Neglect" means failure to perform one's duties according to an accepted professional standard.

"Office" means the Office of the Ombudsman for the Institutionalized Elderly.

"Ombudsperson" means the administrator and chief executive officer of the Office of the Ombudsperson for the Institutionalized Elderly.

"Regional Volunteer Coordinator" means an individual trained and qualified to administer and supervise the Volunteer Advocate Program, and who is capable and willing to promote the Program's philosophy throughout the community being served.

"Resident" means any elderly person who is receiving treatment or care in any facility in all its aspects, including, but not limited to, admission, retention, confinement, commitment, period of residence, transfer, discharge and any instances directly related to such status. For purposes of this chapter, the term "resident" shall also include an elderly patient or client who is receiving treatment or care in any facility, including outpatient services.

"State Program Coordinator" means an individual trained and qualified to administer and supervise the Volunteer Advocate Program throughout the entire State of New Jersey, and who is capable and willing to promote the Program's philosophy throughout the community being served.

"Volunteer Advocate" means an individual trained and certified by the Office to make regular weekly visits to assigned long-term care facilities. A Volunteer Advocate may exercise, but need not be limited to, such functions as visitation, consultation, problem solving, eliciting complaints and generally serving as an advocate on behalf of the institutionalized elderly.

Recodified from N.J.A.C. 8:90-1.2 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

In definition "Abuse", updated the N.J.A.C. reference, in definition "Caregiver", inserted "or contracted"; in definition "Facility", deleted "class 'C' and 'D' boarding homes," following "care homes," deleted "and" preceding "medical day care" and inserted ", and adult family care homes"; substituted definition "Ombudsperson" for definition "Ombudsman"; in definition "Ombudsperson", substituted "Ombudsperson" for "Ombudsman"; in definition "Resident", substituted "this chapter" for "these Regulations" and "resident" for "Resident", and inserted ", including outpatient services"; and added definition "State Program Coordinator".

### 15A:3-1.3 Contact with the Office; information about rights and entitlements; communications

(a) Any person may contact the Office to report any complaints concerning the health, safety and welfare, and the civil and human rights of institutionalized elderly persons.

(b) The Office may be contacted by calling its toll-free telephone number (877-582-6995), 24 hours per day, any day of the year; or by writing to: The Office of the Ombudsperson for the Institutionalized Elderly, Department of the Public Advocate, PO Box 852, Trenton, New Jersey 08625-0852.

(c) Any correspondence or written communication from any resident of a facility to the Office shall, if delivered to or received by the facility, be promptly forwarded, unopened, by the facility to the Office. Any correspondence or written communication from the Office to any resident of a facility shall, if delivered to or received by the facility, be promptly forwarded, unopened, by the facility to such resident.

(d) The Office shall prepare and distribute to each facility written notices which set forth the address and telephone number of the Office, a brief explanation of the function of the Office, the procedure to follow in filing a complaint, and other pertinent information.

(e) The administrator of each facility shall ensure that such written notice is given to every resident or his or her next of kin or guardian, as appropriate, upon admission to the facility and to every person already in residence or his or her next of kin or guardian, as appropriate. The administrator shall also post such written notice in a conspicuous, public place in the facility.

(f) The Office shall from time to time publicize its existence, function and activities by informing residents, their families and friends, facility staff and other caregivers, government agencies and representatives, private organizations and community groups, and the general public, about the Office and its function and activities, through "in-service training" presentations at facilities and elsewhere, participation in seminars or other informational programs, contact with the press and other media, and direct communication, in person or in writing, including the submission for publication of scholarly and informational articles and other materials concerning the Office, its functions and activities.

(g) The Office shall make itself available for the purpose of informing and educating interested individuals and groups about general issues of concern affecting the civil and human rights of the institutionalized elderly.

Administrative correction.

See: 34 N.J.R. 1425(a).

Recodified from N.J.A.C. 8:90-1.3 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

In (b), substituted "Ombudsperson" for "Ombudsman", "Department of the Public Advocate, PO Box 852" for "Department of Health and Senior Services, PO Box 807" and "0852" for "0807".

### 15A:3-1.4 Complaint procedure

(a) If a complaint identifies the complainant, the Office shall acknowledge receipt of all complaints by letter, telephone or e-mail. If the Office does not have jurisdiction, the Office shall so advise the person making the complaint and

shall promptly refer the complaint to the appropriate government agency.

(b) Upon receiving and acknowledging a complaint, the Office shall investigate any act, practice, policy or procedure of any facility or government agency that does or may adversely affect the health, safety, welfare or civil or human rights of any resident of a facility.

(c) The Office need not investigate any complaint where it determines that:

1. The complaint is trivial, frivolous, vexatious or not made in good faith;
2. The complaint has been too long delayed to justify present investigation;
3. The resources available, considering the Office's established priorities, are insufficient for an adequate investigation; or
4. The matter complained of is not within the investigatory authority of the Office.

(d) During the course of any investigation conducted by the Office, the Office may:

1. Make the necessary inquiries and obtain such information as it deems necessary;
2. Hold private hearings or public hearings;
3. Enter without notice and, after notifying the person in charge of its presence, inspect the premises of a facility or government agency and inspect any books, files, medical records or other records that pertain to residents, which are required by law to be maintained by the facility or government agency;
4. Compel at a specific time and place, by subpoena, the appearance and sworn testimony of any person who the Office reasonably believes may be able to give information relating to a matter under investigation; and
5. Compel any person to produce at a specific time and place, by subpoena, any documents, books, records, papers, objects, or other evidence which the Office reasonably believes may relate to a matter under investigation.

(e) Upon completing an investigation of a complaint, the Office shall take one or more of the following courses of action, as appropriate:

1. If Office representatives are unable to substantiate a complaint, the Office shall so advise the complainant and the facility or government agency against whom the complaint was brought, as appropriate. Such notification to a facility or government agency concerning which a complaint was lodged shall not include the identity of the complainant, resident or witnesses, unless such persons authorize, in writing, such disclosure.

2. If Office representatives are able to substantiate a complaint, they may work with facility or government agency representatives, as appropriate, to remedy the problem(s) that exist.

3. In the event that a complaint of a resident or class of residents of a facility or facilities cannot be resolved satisfactorily through negotiation with the facility or the appropriate government agency, or that an act, practice, policy or procedure of a facility or government agency does or may adversely affect the health, safety, welfare or civil or human rights of a resident or class of residents of a facility or facilities, the Office may recommend to the appropriate authorities civil litigation on behalf of such resident or class of residents, as it deems appropriate. The Office may also institute such actions for injunctive relief or civil damages as it deems appropriate.

4. If the Office discovers a deficiency in compliance with State or Federal laws or regulations or rules administered by any government agency, the Office shall refer the matter directly to the appropriate government agency for action.

5. If the Office discovers facts which the Office determines warrant the institution of civil proceedings by a government agency against any person or governmental agency, the matter shall be referred to the government agency with authority to institute such proceedings.

6. If the Office discovers information in relation to the misconduct or breach of duty of any officer or employee of a facility or a government agency, the matter shall be referred to the appropriate authorities for such action as may be necessary.

7. If the Office discovers information or facts indicating the commission of criminal offenses or violations of standards of professional conduct, it shall refer the matter, as appropriate, to the Attorney General, county prosecutor, or any other law enforcement official who has jurisdiction to prosecute the crime, and to the relevant professional licensing board.

(f) The government agency, prosecuting agency or professional licensing board to whom a substantiated allegation has been referred shall report to the Office on its findings and actions with respect to all such referrals within 30 days after receipt thereof and every 30 days thereafter until final action on each such referral. The Office may make disclosure of such information as appropriate and as may be necessary to resolve the matter referred.

(g) Where the Office has substantiated the allegations set forth in a complaint, it shall notify the complainant and the facility or government agency concerning which the complaint was lodged, in writing, of its findings and action taken. Such notification to a facility or government agency concerning which a complaint was lodged shall not include the identity of the complainant, resident or witnesses, unless such persons authorize, in writing, such disclosure.

Recodified from N.J.A.C. 8:90-1.4 by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

**15A:3-1.5 Reporting requirements and complaint procedures under the Mandatory Adult Abuse and Exploitation Reporting Law, N.J.S.A. 52:27G-7.1 et seq.**

(a) Any caregiver, social worker, physician, registered or licensed practical nurse, or other professional, who, as a result of information obtained in the course of his or her employment, has reasonable cause to suspect or believe that an institutionalized elderly person is being or has been abused or exploited, shall report such information to the Office within one business day from the time when such individual acquired such information. Any other person having reasonable cause to suspect or to believe that an elderly person is being or has been abused or exploited may report such information to the Ombudsperson or to the person designated by the Ombudsperson to receive such report.

(b) Any report of actual or suspected elderly abuse or exploitation shall be made verbally or in writing and shall contain, if known:

1. The name, address and age of the elderly person who is the subject of the suspected abuse or exploitation;
2. The name of the person accused of committing the alleged abuse or exploitation;
3. The name and address of the facility involved;
4. A description of the nature of the suspected abuse or exploitation;
5. The date, time and specific location of the occurrence;
6. The name and address of any witness to the suspected abuse or exploitation; and
7. Any other information which might be helpful in an investigation of the case and the protection of such elderly person.

(c) A verbal report, in order to be in compliance with this reporting mandate, must be made directly to a live representative of the Office, and not merely left on an answering machine or voice-mail system.

(d) The Office complaint procedure is as follows:

1. Within 24 hours of receipt of a report of abuse or exploitation, the Office shall notify the Public Advocate or the Public Advocate's designee, and any government agency which regulates or operates the facility.

2. The Office shall investigate a complaint alleging elderly abuse or exploitation by utilizing the procedure set forth in N.J.A.C. 15A:3-1.4. In addition, an investigation shall include a visit with the elderly person who has

allegedly been abused or exploited and consultation with others who have knowledge of the particular case.

(e) Upon completing its investigation, the Office shall report its findings and recommended action, if any, in writing, to:

1. The resident;
2. The resident's legal guardian or other person named on the consent form pursuant to (l) below, by certified and regular mail, except that the Office may withhold reporting to such person upon evidence that such person was a party to the abuse, neglect or exploitation of the resident;
3. The person who reported the suspected abuse or exploitation;
4. The Public Advocate or the Public Advocate's designee;
5. The facility in which the elderly person who was allegedly abused or exploited is residing; such notification shall contain a general description of the Office's investigation and its findings, but shall not include the identity of the complainant, the victim or witnesses, unless such persons authorize, in writing, such disclosure;
6. The county prosecutor's office or any other appropriate prosecuting agency, if a determination is made that an elderly person may have been criminally abused or exploited; and
7. Where the Office has substantiated the allegations of the complaint, and where appropriate, the government agency or agencies having regulatory or licensing authority over either the person accused of the abuse or exploitation or over the facility in which the elderly person is residing.

(f) The name of any person who reports suspected abuse or exploitation pursuant to this subchapter shall not be disclosed, unless:

1. The person who reported the abuse or exploitation specifically authorizes such disclosure;
2. A judicial proceeding results from such report; or
3. Disclosure is authorized under N.J.A.C. 15A:3-1.6(a).

(g) Any person who reports suspected abuse or exploitation pursuant to this subchapter or who testifies in any administrative or judicial proceeding arising from such report or testimony shall have immunity from any civil or criminal liability on account of such report or testimony, unless such person has acted in bad faith or with malicious purpose.

(h) Pursuant to N.J.S.A. 52:27G-7.1(f), any person required to report suspected abuse or exploitation, as required in this section, who fails to make the reports required by this section, shall be fined up to \$5,000. In the event that, within 30 days of notice of assessment of such fine, such person

requests a hearing, the Ombudsperson shall afford said person the right to a hearing in accordance with 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. Such penalty will be collected and enforced by the Office in a summary proceeding brought pursuant to the Penalty Enforcement Law, N.J.S.A. 2A:58-1 et seq. Each violation of this section shall constitute a separate offense.

(i) No provision of this section shall be deemed to require the disclosure of, or penalize the failure to disclose, any information which would be privileged pursuant to the provisions of Sections 18 through 23 inclusive of P.L.1960, c.52 (N.J.S.A. 2A:84A-18 through 2A:84A-23).

(j) The Office shall maintain a central registry of all reports of suspected abuse or exploitation and of all investigations, findings and recommended actions. No information received and compiled in such registries shall be construed as a public record.

(k) Where the report alleging elderly abuse or exploitation pertains to the withholding or withdrawal of life-sustaining treatment from an incapacitated elderly resident, reporting shall be governed by N.J.A.C. 15A:3-2.

(l) Each facility shall provide a Disclosure Consent Form, as set forth in chapter Appendix A, incorporated herein by reference, for every resident upon admission to the facility. The form is to be signed only by the resident or a judicially-appointed guardian of the person of the resident. Neither a "responsible" party nor a holder of the resident's financial or health care power of attorney has the legal authority to complete this form. If the resident is incapable of signing the form and has no guardian, the facility shall make a notation to that effect on the form.

Recodified from N.J.A.C. 8:90-1.5 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

In (a), substituted "Ombudsperson" for "Ombudsman" two times; in (d)1 and in (e)4, substituted "Public Advocate or the Public Advocate's" for "Commissioner of Health and Senior Services, or that Commissioner's"; in (d)1, deleted "other" preceding "government agency"; in (d)2, (f)3 and (k), updated the N.J.A.C. references; in (h) substituted "Ombudsperson" for "Ombudsman, as the agency head,"; in (k), substituted "incapacitated elderly" for "elderly incompetent institutionalized"; and in (l), substituted "signed" for "completed" and added the last sentence.

### **15A:3-1.6 Confidentiality of information; privileged communications**

(a) The Office shall maintain confidentiality with respect to all matters in relation to any complaint or investigation, together with the identities of the complainants, witnesses or residents involved, unless such persons authorize, in writing, the release of such information, except for such disclosures as the Ombudsperson deems necessary to enable the Office to perform its duties and to support any opinions or recommendations that may result from a complaint or investigation. The investigatory files of the Office, including all complaints and

responses of the Office to complaints, shall be maintained as confidential information. Release of pertinent records shall be at the discretion of the Ombudsperson.

(b) Any statement or communication made by the Office relevant to a complaint received by, proceedings before, or investigative activities of, the Office, and any complaint or information made or provided in good faith by any person, shall be absolutely privileged and such privilege shall be a complete defense in any action which shall allege libel or slander.

Recodified from N.J.A.C. 8:90-1.6 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

In (a), substituted "Ombudsperson" for "Ombudsman" two times.

#### **15A:3-1.7 Prohibition of discriminatory, disciplinary or retaliatory action**

No discriminatory, disciplinary or retaliatory action shall be taken against any officer or employee of a facility or government agency by such facility or government agency, or against any resident of a facility or guardian or family member thereof, or independent contractor providing care or services to a resident, or volunteer, for any communication by him or her with the Office or for any information given or disclosed by him or her in good faith to aid the Office in carrying out its duties and responsibilities.

Recodified from N.J.A.C. 8:90-1.7 by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

#### **15A:3-1.8 Hindrance of Office or refusal to comply; penalties**

Any person who willfully hinders the lawful actions of the Office or willfully refuses to comply with any of its lawful demands, including the demand of immediate entry into and inspection of a facility or government agency or the demand of immediate access to a resident thereof, shall be fined up to \$5,000. In the event that, within 30 days of notice of assessment of such fine, such person requests a hearing, the Ombudsperson shall afford said person the right to a hearing in accordance with 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. Such penalty shall be collected and enforced by the Office in a summary proceeding brought pursuant to the Penalty Enforcement Law, N.J.S.A. 2A:58-1 et seq., upon complaint of the Office or any other person. Each violation of this section shall constitute a separate offense.

Recodified from N.J.A.C. 8:90-1.8 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

Substituted "Ombudsperson" for "Ombudsman, as the Agency Head."

#### **15A:3-1.9 Volunteer Advocate Program**

(a) The State Program Coordinator, under the direction of the Ombudsperson, shall develop programs for use, training and coordination of volunteers and shall also be responsible for the development of policies and procedures for the administration of the Volunteer Advocate Program. These Volunteer Advocates shall serve to promote the well-being and quality of life of residents of long-term care facilities. They shall be required to report to the Regional Volunteer Coordinator.

(b) The Office shall retain responsibility for its volunteer advocates by acquiring the services of Regional Volunteer Coordinators, who shall be responsible to the Ombudsperson through the State Program Coordinator. The Regional Volunteer Coordinator shall recruit, train and supervise Volunteer Advocates to advocate on behalf of the institutionalized elderly 60 years of age and over.

(c) The State Program Coordinator, under the direction and supervision of the Ombudsperson shall coordinate the efforts of the Volunteer Advocate program for the Office with all relevant government agencies and with the administrators of such private facilities as may be deemed appropriate to ensure coordination and to avoid duplication of effort, so that the Volunteer Program will genuinely serve the interests of the institutionalized elderly without disrupting the legitimate function of any facility.

Recodified from N.J.A.C. 8:90-1.9 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

In (a), substituted "State Program Coordinator, under the direction of the Ombudsperson" for "Office"; in (b), substituted "Regional Volunteer Coordinators" for "a Regional Volunteer Coordinator" and "Ombudsperson through the State Program Coordinator" for "Ombudsman"; and in (c), substituted "State Program Coordinator, under the direction and supervision of the Ombudsperson" for "Ombudsman", inserted "of the Volunteer Advocate program" and deleted "concerning volunteers" following "Office".

### **SUBCHAPTER 2. PROCEDURES REQUIRED PRIOR TO WITHHOLDING OR WITHDRAWING LIFE-SUSTAINING TREATMENT FROM ELDERLY, INSTITUTIONALIZED RESIDENTS**

#### **15A:3-2.1 Purpose**

(a) The purpose of this subchapter is to clarify the Office's role in circumstances involving proposals to withhold or to withdraw life-sustaining treatment residents of facilities, pursuant to guidelines set forth by the New Jersey Supreme Court in the cases of *Matter of Farrell*, 108 N.J. 335 (1987), *Matter of Peter*, 108 N.J. 365 (1987), *Matter of Jobes*, 108 N.J. 394 (1987), and *Matter of Conroy*, 98 N.J. 321 (1985). The Office views its role as being twofold:

1. To oversee the processes established by the Court in *Peter* and in *Conroy*; and

2. To assist the institutionalized elderly, their families and friends, their healthcare providers and the facilities in which they reside in making life-sustaining treatment decisions that fully express the wishes of the resident.

(b) Where there is no clear “duty to report” as outlined in N.J.A.C. 15A:3-2.3, the Office is available to provide technical support, assistance and dispute resolution, should there be disagreement regarding the withholding or withdrawal of life-sustaining treatment, whether or not the resident has the capacity to make a healthcare decision, and whether or not an Advance Directive (“Living Will”) or Proxy Directive (“Durable Power of Attorney for Health Care”) is involved. The Office’s function in any such situation is to promote, advocate and ensure the rights of the institutionalized elderly resident, pursuant to New Jersey Supreme Court guidelines and the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq.

Recodified from N.J.A.C. 8:90-2.1 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

In (b), updated the first N.J.A.C. reference.

### 15A:3-2.2 Definitions

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

“Advanced practice nurse” means a person certified by the New Jersey Board of Nursing in accordance with the Advanced Practice Nurse Certification Act (“APNCA”), N.J.S.A. 45:11-45 et seq. All orders written by an advanced practice nurse pursuant to this subchapter must be done in accordance with the procedures established by the APNCA and implementing regulations.

“Capacity to make a healthcare decision” means the ability to understand and appreciate the nature and consequences of a particular healthcare decision, including the resident’s diagnosis and prognosis, the burdens, benefits and risks associated with the decision and alternatives to the decision, and having the ability to make judgments about that information.

“Family member” shall mean, in order of priority, the resident’s spouse in a marriage or a civil union, parents, children, or next of kin, if any.

“Fully informed” means being informed in language understandable to the resident of diagnosis and prognosis, the benefits, burdens and risks of the proposed treatment or non-treatment and its alternatives.

“Incapacitated” means lacking the capacity to make health care decisions, as defined above.

“Life-sustaining treatment” means any medical intervention that is administered to a resident in order to prolong life and delay death, including, but not limited to, medication,

artificial nutrition, artificial hydration, and artificial respiration.

“Medically indicated treatment” means treatment that will improve the medical condition of the resident or is necessary to provide palliative care to the resident.

“Ombudsperson” means the Ombudsperson for the Institutionalized Elderly, or that person’s designee.

“Palliative care” means medical, surgical or other interventions designed to alleviate suffering and discomfort, but not to cure.

“Permanently unconscious” is a medical diagnosis, which means that a person is not likely to return to a state of consciousness. For purposes of this subchapter, this term includes a medical diagnosis of “persistent vegetative state.”

“Regional Long-Term Care Ethics Committee” means a group composed of healthcare and community members, who have participated in an Ombudsperson-approved training course, and acting under the auspices and with the approval of the Ombudsperson, provides education, policy development, and case consultation services to its member facilities.

“Surrogate decision-maker” means a guardian, a close and caring family member, a domestic partner, as defined in section 3 of P.L. 2003, c. 246 (N.J.S.A. 26:8A-3) or a person designated by the resident, including a health care representative or health care proxy appointed pursuant to N.J.S.A. 26:2H-58, who is willing and able to make a decision to withhold or to withdraw life-sustaining treatment on behalf of the resident.

Recodified from N.J.A.C. 8:90-2.2 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

In definition “Capacity to make a healthcare decision”, deleted “voluntarily reason and” preceding “make judgments”; in definition “Family member”, inserted “a civil union.”; deleted definition “Non-attending physician”; added definitions “Ombudsperson” and “Regional Long-Term Care Ethics Committee”; and in definition “Surrogate decision-maker”, inserted “a domestic partner, as defined in section 3 of P.L. 2003, c. 246 (N.J.S.A. 26:8A-3)” and substituted “including” for “except”.

### 15A:3-2.3 Duty to report

(a) Any person who believes that withholding or withdrawing life-sustaining treatment from an elderly, incapacitated resident of a facility would effectuate the resident’s wishes or would be in the resident’s best interests shall notify the Office of the contemplated action.

(b) Any caregiver, social worker, physician, registered or licensed practical nurse or other professional who has reasonable cause to suspect that withholding or withdrawing life-sustaining treatment from an elderly, incapacitated resident of a facility would be an abuse of that resident shall report such information to the Office.

(c) Any other person who has reasonable cause to suspect that withholding or withdrawing life-sustaining treatment from an elderly, incapacitated resident of a facility would be an abuse of the resident may report such information to the Office.

(d) The reporting procedures set forth in this section shall not apply when:

1. The resident is under age 60;
2. The resident, being fully informed and having the capacity to make a health care decision, chooses to withhold or withdraw life-sustaining treatment. Where there is any doubt whether the resident is fully informed, or regarding the resident's capacity to make a particular health care decision, two non-attending physicians shall make the determination of whether the resident is fully informed and has the capacity to make a particular health care decision. The physicians' determinations shall be based on the physicians' reasonable medical judgments and shall be documented on the resident's chart;
3. The resident has a fully executed and valid Advance Directive ("Living Will") or Proxy Directive ("Durable Power of Attorney for Health Care") under the provisions of N.J.S.A. 26:2H-53 et seq.;
4. The life-sustaining treatment is not medically indicated for the resident. The resident's attending physician or an advanced practice nurse in collaboration with the attending physician shall make this determination. Such determination shall be based on reasonable medical judgment and shall be documented on the resident's chart;
5. The proposal to withhold or withdraw life-sustaining treatment is being reviewed by, or has been reviewed favorably by, a court of competent jurisdiction; or
6. The proposal to withhold or withdraw life-sustaining treatment is being reviewed by, or has been reviewed by, a regional long term care ethics committee acting under the auspices of and with the approval of the Ombudsperson, and such committee has recommended in favor of the proposal and reported its recommendation to the Ombudsperson.

Recodified from N.J.A.C. 8:90-2.3 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

In (d)6, substituted "Ombudsperson" for "Ombudsman" and inserted "and reported its recommendation to the Ombudsperson".

#### **15A:3-2.4 Procedure for residents incapable of making healthcare decisions**

(a) Unless one or more of the circumstances set forth in N.J.A.C. 15A:3-2.3(d) apply, the surrogate decision-maker for the resident shall notify the Office, in writing, of a contemplated decision to withhold or to withdraw life-sustaining treatment from the resident.

(b) The resident's attending physician or advanced practice nurse shall provide to the Office, in writing, evidence of the resident's condition.

(c) The Office shall advise the facility administrator, in writing, of the proposal to withhold or to withdraw life-sustaining treatment.

(d) The Office shall then inquire into the resident's intent, if any, pertaining to the proposal to withhold or to withdraw the life-sustaining treatment. In making its intent inquiry, the Office shall:

1. Inquire into whether there exists any declaration or designation including an oral declaration or designation;
2. Make reasonable efforts to interview the resident's family and friends, the attending physician, healthcare providers, employees of the facility at which the resident is residing, and others having knowledge of the resident's intent; and
3. Do anything that the Office, in its discretion, deems necessary to discover the resident's intent.

(e) Concurrent with its intent inquiry, the Office shall engage the services of two physicians, unaffiliated with the facility and with the attending physician, to confirm the resident's medical condition and prognosis.

1. The Office shall provide to each physician, in writing, an explanation of the areas that must be covered in the physician's report. The areas are:
  - i. The date(s) of the physician's examination(s) and the identity of anyone assisting or accompanying the physician;
  - ii. A synopsis of the physician's examination(s), the resident's medical history on which the physician bases his or her conclusions and any limitations on either, which the physician believes significant. The physician should also advise whether the medical history indicates whether the resident ever was competent during adult life;
  - iii. The resident's diagnosis and condition;
  - iv. The medical alternatives available including the various treatment options and the risks, side effects and benefits of each of those options;
  - v. The resident's prognosis, both with and without the life-sustaining treatment which has been proposed to now be withheld or withdrawn;
  - vi. Whether the resident is in a persistent vegetative state because there is no reasonable possibility of the resident's recovery to a cognitive, sapient state;
  - vii. The likely outcome if treatment is discontinued or withheld;

viii. Whether the resident currently has the mental and communicative capacity to reasonably understand his or her own condition, the nature and effect of the medical treatment proposed to be withheld or withdrawn, the attendant risks in selecting such treatment, and to decide whether or not to submit to such treatment;

ix. A brief description of the resident and whether the resident was able to communicate anything about his or her own condition to the physician;

x. The resident's present level of:

- (1) Physical functioning;
- (2) Sensory functioning;
- (3) Emotional functioning; and
- (4) Cognitive functioning;

xi. The degree of pain resulting from the resident's medical condition, the resident's medical treatment, and terminating or withholding treatment, including the degree, expected duration and constancy of pain (with and without treatment) and the possibility that the pain could be reduced by drugs or other means short of terminating or withdrawing the life-sustaining treatment;

xii. The resident's life expectancy with and without the treatment in question. In particular, whether or not the resident, even with the life-sustaining treatment, likely will not live more than one year from the date of the physician's examination; and

xiii. Whether the patient likely will regain capacity, with or without the proposed treatment.

2. After reviewing the Office's correspondence, each physician shall acknowledge, in writing, his or her agreement to perform the examination.

3. Each physician shall then travel to the facility and perform the examination. An Office representative shall be at the facility to assist each physician.

4. Each physician shall promptly provide to the Office a written report of the physician's conclusions.

5. The identity of each physician and the contents of each report shall be confidential.

6. Each physician shall be compensated by one or more of the following:

- i. The resident's estate;
- ii. The resident's family;
- iii. The surrogate decision-maker;
- iv. The facility;
- v. Medicare or Medicaid; and/or

vi. If the above sources are insufficient to compensate the physicians, the Office of the Ombudsperson shall compensate the physicians, within the limitations of the Office's budget.

(f) Upon completion of the intent inquiry and the physicians' examinations, if both physicians conclude that the resident is permanently unconscious or in a persistent vegetative state, the surrogate decision-maker may withhold or withdraw the life-sustaining treatment if:

1. There exists clear and convincing evidence that the resident would have refused the life-sustaining treatment in the circumstances involved; or

2. If there does not exist clear and convincing evidence regarding the resident's attitude toward life-sustaining treatment, the surrogate decision-maker may withhold or withdraw the life-sustaining treatment if both physicians have also concluded that there is no reasonable possibility that the resident will recover to a cognitive, sapient state. Additionally, the attending physician must concur with the conclusion of both independent physicians and the Ombudsman concurs that the withholding or withdrawing of treatment is appropriate under the circumstances.

(g) A surrogate decision-maker may seek a determination in a court of competent jurisdiction where the Ombudsperson does not concur.

(h) If (f)2 above is satisfied, the resident's family member must also concur with the surrogate decision-maker's decision. A family member or domestic partner, as defined in section 3 of P.L. 2003, c. 246, N.J.S.A. 26:8A-3 who opposes or disagrees with the decision of the surrogate decision-maker retains the right to challenge that decision in a court of competent jurisdiction.

(i) Upon completion of the intent inquiry and the physicians' examinations, if both physicians find that the resident is not permanently unconscious or in a persistent vegetative state, but is incapable of making a healthcare decision, is suffering from severe and permanent mental and physical impairments, and probably would have less than one year to live from the date of the examination with or without life-sustaining treatment, the surrogate decisionmaker may withhold or withdraw the life-sustaining treatment if:

1. There exists clear and convincing evidence that the resident would have refused the life-sustaining treatment in the circumstances involved;

2. There exists some trustworthy evidence that the resident would have refused the life-sustaining treatment in the circumstances involved, and on the basis of the medical evidence, the surrogate decision-maker is satisfied that it is clear that the burdens of the resident's continued life with the treatment outweighs the benefit of the resident's continued life and the Ombudsperson concurs that withholding

or withdrawing of treatment is appropriate under the circumstances; or

3. There exists no evidence of the resident's intent, but on the basis of the medical evidence, the net burdens of the resident's life with the treatment clearly and markedly outweigh the benefits that the resident would derive from life. Additionally, the recurring, unavoidable and severe pain of the resident's life with the treatment would be such that the effect of administering the life-sustaining treatment would be inhumane; and the Ombudsperson concurs that withholding or withdrawing of treatment is appropriate under the circumstances.

(j) The surrogate decision-maker may seek a determination in a court of competent jurisdiction where the Ombudsperson does not concur.

(k) If either of (i)2 or 3 above is satisfied, the resident's family member must also concur with the decision made by the surrogate decision-maker. Any family member or domestic partner who opposed or disagrees with the decision of the surrogate decision-maker retains the right to challenge that decision in a court of competent jurisdiction.

(l) In the absence of bad faith, no participant in the decision-making process shall be civilly or criminally liable.

Recodified from N.J.A.C. 8:90-2.4 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

In (a), updated the N.J.A.C. reference; in the introductory paragraph of (d), deleted "surrogate decision-maker's" preceding "proposal"; rewrote the introductory paragraph of (e); in (e)1, substituted the first occurrence of "The" for "Prior to the examination, the" and "physician's report" for "report of the examination"; in (e)1v, deleted "for recovery" following "prognosis"; in (e)1xii and (e)1xiii, substituted "likely" for "probably"; in (e)1xiii, substituted "capacity, with or without the proposed treatment" for "competence"; in (e)4, substituted "Each" for "Upon completing the examination, each" and "physician's conclusions" for "examination", and inserted "promptly"; in (e)5, deleted "kept" preceding "confidential"; in (e)6vi, (g), (i)2, (i)3 and (j), substituted "Ombudsperson" for "Ombudsman"; in (h) and (k), substituted "If" for "When" and "challenge that decision" for "seek a determination"; in (h), inserted "or domestic partner, as defined in section 3 of P.L. 2003, c. 246, N.J.S.A. 26:8A-3"; and in (k), inserted "or domestic partner".

### 15A:3-2.5 Use of "Do Not Resuscitate" orders in facilities

(a) "Do Not Resuscitate" orders ("DNRs") are orders written by a physician or advanced practice nurse in collaboration with a physician, which must be made part of the resident's medical record in the same way as any other order.

(b) DNRs can be appropriately utilized in a facility, provided the following safeguards are employed:

1. Prior to writing a DNR, the attending physician or advanced practice nurse after consultation with the attending physician shall:

i. Discuss the circumstances surrounding his or her decision to enter such an order with the resident, or if the

resident is incapacitated, with the resident's surrogate decision-maker or health care proxy, as appropriate;

ii. If a resident has a court appointed guardian, consult with that guardian before the DNR order is written;

iii. If there is no surrogate decision maker, designated proxy, or guardian, the physician or advanced practice nurse shall exercise his or her best professional judgment regarding the order, and may seek consultation with the Ombudsperson or a regional long-term care ethics committee;

iv. Document the above-referenced discussions; and

v. Document the resident's medical history, diagnosis, prognosis as they relate to the DNR.

2. The DNR shall be clear and precise, and include appropriate plan of palliative care;

3. If the resident has the capacity to make health care decisions, and requests that the attending physician or advanced practice nurse place a DNR on his or her chart, the attending physician or advanced practice nurse in collaboration with the attending physician shall determine that the resident is fully informed, aware of his or her diagnosis and prognosis, the risks, benefits and any alternatives, that this is in fact the resident's wish, and that there is no coercion;

4. If a resident is transferred from an acute care hospital to a facility, and a DNR had been written in the hospital, that order shall be thoroughly reviewed and rewritten by the facility attending physician or advanced practice nurse in collaboration with the facility attending physician and in accordance with facility policy; and

5. If the resident has executed a DNR clause as part of an Advance Directive, that clause shall not be effective as a DNR order unless and until the attending physician or advanced practice nurse in collaboration with the attending physician has followed (b)1 through 4 above, and entered a DNR order in the resident's medical record.

(c) A resident, responsible family member, a health care proxy, or a surrogate decision-maker can initiate the request that the physician or advanced practice nurse write a DNR and enter it in the resident's medical record.

Recodified from N.J.A.C. 8:90-2.5 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

Added (b)liii; recodified former (b)liii and (b)liv as (b)liv and (b)lv; and in (b)4, inserted "and in accordance with facility policy".

### 15A:3-2.6 Use of "Do Not Hospitalize" orders in facilities

(a) "Do Not Hospitalize" orders ("DNHs") are orders written by a physician or advanced practice nurse in collaboration with a physician, which must be made part of the resident's medical record in the same way as any other order.

(b) DNHs can be appropriately utilized in a facility, provided the following safeguards are employed:

1. Prior to writing a DNH, the attending physician or advanced practice nurse after consultation with the attending physician shall:

i. Discuss the circumstances surrounding his or her decision to enter such an order with the resident, or if the resident is incapacitated, with the resident’s surrogate decision-maker or Health Care Proxy, as appropriate;

ii. If a resident has a court appointed guardian, consult with that guardian before the DNH order is written;

iii. If there is no surrogate decision maker, designated proxy, or guardian, the physician or advanced practice nurse shall exercise his or her best professional judgment regarding the order, and may seek consultation with the Ombudsperson or a regional long-term care ethics committee;

iv. Document the above-referenced discussions; and

v. Document the resident’s medical history, diagnosis, prognosis as they relate to the DNH;

2. The DNH shall be clear and precise, and include appropriate plan of palliative care;

3. If the resident has the capacity to make health care decisions, and requests that the attending physician or advanced practice nurse place a DNH on his or her chart, the attending physician or advanced practice nurse in collaboration with the attending physician shall determine that the resident is fully informed, aware of his or her diagnosis and prognosis, the risks, benefits and any alternatives, that this is in fact the resident’s wish, and that there is no coercion; and

4. If the resident has executed a DNH clause as part of an Advance Directive, that clause shall not be effective as a DNH order unless and until the attending physician or advanced practice nurse in collaboration with the attending physician has followed (b)1 through 3 above, and entered a DNH order in the resident’s medical record.

(c) A resident, responsible family member, a health care proxy, or a surrogate decision-maker can initiate the request that the physician or advanced practice nurse write a DNH and enter it in the resident’s medical record.

(d) The utilization of a DNH does not prohibit a facility from sending a resident to the hospital in appropriate instances, for example, for sutures in the case of a laceration, or for x-rays after a fall.

(e) The appropriateness of sending a resident with a DNH to the hospital shall be evaluated and determined by the physician or advanced practice nurse in light of the presenting problem and the resident’s overall medical condition.

Recodified from N.J.A.C. 8:90-2.6 and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

Added (b)liii; recodified former (b)liii and (b)liv as (b)liv and (b)lv; and in (e), substituted “physician or advanced practice nurse” for “caregivers”.

APPENDIX A

OMBUDSPERSON DISCLOSURE CONSENT FORM

In New Jersey, persons over the age of 60 who reside in licensed facilities are fortunate to have an individual appointed by the Governor whose responsibility it is to promote, advocate and ensure the adequacy of care and quality of life you experience. This individual is the Ombudsperson for the Institutionalized Elderly. One of the Ombudsperson’s roles is to investigate complaints of abuse and exploitation. Should such a complaint ever arise, this form gives you or your judicially-appointed guardian the power to authorize the release of any findings of any investigation of this nature to the person(s) you or your guardian choose.

In the event of an investigation by the Ombudsperson relating to my care, I hereby authorize the Ombudsperson to release the results of such an investigation to the following person(s):

(1) Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

(2) Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

The Ombudsperson shall not be required to disclose the results of any investigation to any person other than me, a guardian appointed for me by a Court, a duly authorized holder of a power of attorney for health care, or the person(s) named on this consent form.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

\_\_\_\_\_

*Note: This form is to be completed ONLY by the resident or a judicially-appointed guardian of the person of the resident. Neither a “responsible” party nor a holder of the resident’s financial power of attorney has the legal authority to complete this form.*

\_\_\_\_\_

Recodified from N.J.A.C. 8:90 Appendix A and amended by R.2007 d.366, effective December 3, 2007.

See: 39 N.J.R. 2219(a), 39 N.J.R. 5101(a).

Section was “Ombudsman Disclosure Consent Form”. Substituted “Ombudsperson” for “Ombudsman” throughout; in the introductory