

Repeal and New Rule, R.2001 d.287, effective August 20, 2001.

See: 32 N.J.R. 4073(a), 33 N.J.R. 2893(a).

Section was "Newly constructed or expanded facilities".

#### 8:43H-2.4 Suitability review approval

(a) Suitability review approval shall remain in effect for a period of two years from the date of approval.

(b) Notwithstanding any of the provisions as set forth in this chapter, suitability review approval is advisory only and shall not be construed as a guarantee of eventual licensure approval in any case.

(c) Notwithstanding any of the provisions as set forth in this chapter, in order to obtain a license, every facility and/or service shall comply with applicable licensure standards in N.J.A.C. 8:43H-2.5, and at all times thereafter.

Repeal and New Rule, R.2001 d.287, effective August 20, 2001.

See: 32 N.J.R. 4073(a), 33 N.J.R. 2893(a).

Section was "Surveys and temporary license".

#### 8:43H-2.5 Licensure application

(a) The applicant shall submit to the Department a non-refundable fee of \$8,000 for the filing of an application for licensure of a rehabilitation hospital and a nonrefundable \$8,000.00 for the annual renewal of the license. First time licensure applicants shall pay both the new facility fee and the nonrefundable biennial inspection fee of \$4,000 upon filing an application. Renewal applicants will be subject to the biennial fee in accordance with the Department's inspection schedule.

(b) All applicants must demonstrate character and competence, the ability to provide quality of care commensurate with applicable licensure standards, and an acceptable track record of past and current compliance with in-and out-of-State licensure requirements for new licenses, as applicable, and Federal requirements, as applicable, including, but not limited to the following:

1. The performance of the applicant in meeting its obligations under any previously approved New Jersey certificate of need, where applicable, including full compliance with all conditions of approval, if applicable; and

2. The capacity to provide quality care which meets or surpasses the requirements contained in applicable licensure standards pertinent to the proposed facility and/or service, as set forth below:

i. Applicants shall demonstrate a satisfactory record of compliance with licensure standards in existing health care facilities which are owned, operated, or managed, in whole or in part, by the applicant, according to the provisions in (h) below. In addition to

demonstrating compliance with in-State licensure provisions, applicants must also include reports issued by licensing agencies in other states, where applicable;

ii. Applicants shall include narrative descriptions of staffing patterns, policies and protocols addressing delivery of nursing, medical, pharmacy, dietary, and other services affecting quality of care to patients; and

iii. Applicants shall include documentation of compliance with the standards of accreditation of nationally-recognized professional bodies.

(c) The Department shall examine and evaluate the licensure track record of each applicant for the period beginning 12 months preceding the submission of the application and extending to the date on which a determination is made either to approve or deny the license, for the purpose of determining the capacity of an applicant to operate a health care facility in a safe and effective manner, in accordance with State and Federal requirements. An application for a license may be denied where an applicant has not demonstrated such capacity, as evidenced by continuing violations, a pattern of violations of State licensure standards or Federal conditions of participation standards, or existence of a criminal conviction or a plea of guilty to a charge of fraud, patient or resident abuse or neglect, or crime of violence or moral turpitude. An application may also be denied where an applicant has violated any State licensing or Federal certification standards in connection with an inappropriate discharge or denial of admission of a patient. An applicant, for purposes of this section, includes any person who was or is an owner or principal of a licensed health care facility, excluding individuals or entities who are limited partners with no managerial control or authority over the operation of the facility and who have an ownership interest of 10 percent or less in a corporation which is the applicant and who also do not serve as officers or directors of the applicant corporation.

(d) An applicant for a new license who operates or manages licensed or Federally certified health care facilities in other states, shall have performed an evaluation of each facility's compliance with state and Federal licensing and certification requirements during the 12 months preceding application submission and extending to the date on which a determination is made to either approve or deny the license. This information shall be submitted on the letterhead of the state agency responsible for health facility inspection, monitoring, and enforcement of state and Federal requirements. The following information shall be included:

1. Written notice that the subject facilities have been in substantial compliance with licensing and/or certification requirements during the 12 months immediately preceding application submission; and

2. In instances in which substantial compliance has not been achieved, a description of the deficiency or deficiencies and a description of penalties and other enforcement action imposed by the state agency and/or imposed by, or recommended to the Health Care Financing Administration.

(e) An applicant for license who was cited for any state licensure or Federal certification deficiency during the period identified in (c) and (d) above, which presented a serious risk to the life, safety, or quality of care of the facility's patients or residents, shall be denied, except in cases where the applicant has owned/operated the facility for less than 12 months and the deficiencies occurred during the tenure of the previous owner/operator. In any facility, the existence of a track record violation during the period identified in (c) and (d) above shall create a rebuttable presumption, which may be overcome as set forth below in this subsection, that the applicant is unable to meet or surpass licensure standards of the State of New Jersey. Those applicants with track record violations which would result in denial of the application shall submit with their application any evidence indicating that the track record violations do not presage operational difficulties and quality of care violations at the facility which is the subject of the application or in any other licensed facility in New Jersey, which is operated or managed by the applicant. If after review of the application and the evidence submitted to rebut a negative track record, the Commissioner denies the application, the applicant may request a hearing which will be held 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. At the Commissioner's discretion, the hearing shall be conducted by the Commissioner or transferred to the Office of Administrative Law. The purpose of the hearing is to provide the applicant with the opportunity to present additional evidence in conjunction with evidence already included with the initial application, for the purpose of demonstrating the applicant's operational history and capacity to deliver quality of care to patients or residents which meets or surpasses licensure standards of the State of New Jersey to the satisfaction of the Commissioner or his or her designee. The conclusion of that process with either a decision by the Commissioner, or the Commissioner's acceptance or denial of an initial decision by an administrative law judge, shall constitute a final agency decision. A serious risk to life, safety, or quality of care of patients or residents includes, but is not limited to, any deficiency in State licensure or Federal conditions of participation requirements (42 C.F.R. 488.400) resulting in:

1. An action by a state or Federal agency to ban, curtail or temporarily suspend admissions to a facility or to suspend or revoke a facility's license; or

2. A termination, or exclusion from Medicaid, or Medicare participation, including denial of payment for new admissions, imposed by the Department or by the Health Care Financing Administration, as a result of noncompliance with Medicaid or Medicare conditions of participation.

(f) The criteria for denial of an application specified in (c) through (e) above shall also result in denial of a new license if the criteria are found to have been true of the lower of five facilities or five percent of out-of-State facilities operated or managed by the applicant, within the 12 months preceding submission of the application and extending to the date on which a determination is made to either approve or deny the license and with respect to any service which is similar or related to the proposed service.

(g) In addition to the provisions of (c) through (e) above, and notwithstanding any express or implied limitations contained therein, the Commissioner or Commissioner's designee may deny any application where he or she determines that the actions of the applicant at any facility operated or managed by the applicant constitute a threat to the life, safety, or quality of care of the patients or residents. In exercising his or her discretion under this subsection, the Commissioner shall consider the following:

1. The scope and severity of the threat;
2. The frequency of occurrence;
3. The presence or absence of attempts at remedial action by the applicant;
4. The existence of any citations, penalties, warnings, or other enforcement actions by any governmental entity pertinent to the condition giving rise to the threat;
5. The similarity between the service within which the threat arose and the service which is the subject of the application; and
6. Any other factor which the Commissioner deems to be relevant to assessment of risk presented to patients or residents.

(h) For the purposes of this section, comprehensive rehabilitation care shall be considered similar to the acute care category which includes hospital services such as medical/surgical, pediatric, cardiac, psychiatric, intensive care/critical care, surgical services, magnetic resonance imaging and computerized tomography, lithotripsy, renal dialysis, obstetric, and birth centers.

(i) Each rehabilitation hospital shall be assessed a nonrefundable biennial inspection fee of \$4,000. For existing facilities, 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 licensing fee for new facilities. Failure to pay the inspection fee shall result in non-renewal 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.

Repeal and New Rule, R.2001 d.287, effective August 20, 2001.

See: 32 N.J.R. 4073(a), 33 N.J.R. 2893(a).  
Section was "Full license".

### 8:43H-2.6 Licensure

(a) A license shall be issued if surveys by the Department have determined that the rehabilitation hospital is being operated as required by N.J.S.A. 26:2H-1 et seq. and amendments thereto, and by this chapter.

(b) At the request of the applicant, an office conference for review of the conditions for licensure and operation may take place between Certificate of Need and Acute Care Licensing Program representatives within the Department and the applicant, who shall be advised that the purpose of the conference is to allow the Department to determine whether the applicant complies with this chapter.

(c) When the written application for licensure has been submitted and the building is ready for occupancy and/or use, a survey of the facility by representatives of the Department shall be conducted to determine if the facility complies with the pertinent licensure rules. Applicants shall provide the Department's Inspection, Complaints and Compliance Program with at least 45 days notice of the date they want the survey to occur.

(d) Subsequent survey visits may be made to a rehabilitation hospital any time, or to a patient's home with the patient's consent, by authorized staff of the Department. Such visits may include, but not be limited to, a review of all facility documents and patient records, and conferences with patients and/or their families.

(e) Surveys shall be conducted, deficiencies reported, disputes resolved, and plans of correction submitted in accordance with N.J.A.C. 8:43E-2.

(f) A license shall be issued to a rehabilitation hospital for a period of one year when the following conditions are met:

1. Written approvals are on file with the Department from the local zoning, fire, health, and building authorities, or a certificate of occupancy or a certificate of continued occupancy has been issued by the local municipality; and

2. Survey(s) by representatives of the Department indicate that the rehabilitation hospital complies with the pertinent licensure rules.

(g) The license shall be conspicuously posted at the rehabilitation hospital.

(h) No rehabilitation hospital shall accept patients until the facility has the written approval and/or license issued by the Department.

(i) Except as set forth below, the license is not assignable or transferable, and it shall be immediately void if the

rehabilitation hospital ceases to operate, if the rehabilitation hospital ownership changes, if the rehabilitation hospital is relocated to a different site, or if a component part of a rehabilitation hospital ceases to operate.

1. If the rehabilitation hospital or a component thereof ceases to operate, the licensee may request that the Department maintain the license for a period of up to 24 months. The licensee shall make such a request at least 30 days prior to ceasing operations, and such request shall include the rationale and the timeframe for the extension.

2. In the case of a transfer of ownership, new owners of a rehabilitation hospital shall make application for licensure with the Department, in accordance with the provisions as set forth in N.J.A.C. 8:43H-2.1 and this subchapter. In addition, the following information shall be submitted with the application:

- i. A description of the proposed transfer of ownership, in detail, including total purchase cost;

- ii. Identification of 100 percent of the current and prospective ownership of both the physical assets of the comprehensive rehabilitation hospital and the operation of the comprehensive rehabilitation hospital;

- iii. Where applicable, 100 percent of the ownership of leased buildings and property; and

- iv. Copies of all legal documents pertinent to the transfer of ownership transaction which are signed by both the current licensed owners and the proposed licensed owners.

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

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

(l) Failure to renew a license shall constitute operation of a health care facility without a license and may result in issuance by the Department of a cease and desist order, in accordance with N.J.A.C. 8:43E-3.11 and other penalties in accordance with N.J.A.C. 8:43E-3.4(a)l.

(m) To qualify for licensure as a new freestanding rehabilitation hospital, the minimum bed size required is 60 beds. To qualify for licensure as a licensed health care facility-based comprehensive rehabilitation unit, the minimum bed size required is 30 beds.

(n) To maintain licensure as an adult rehabilitation hospital or unit, 75 percent of patient days annually must fall into the following diagnostic categories:

1. Stroke;
2. Spinal cord injury;
3. Congenital deformity;
4. Amputation;
5. Major multiple trauma;
6. Fractures of femur;
7. Brain injury;
8. Burns;
9. Polyarthritis, including rheumatoid arthritis; and
10. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(o) To maintain licensure as a pediatric rehabilitation hospital/ unit, 75 percent of patient days annually must fall into the following diagnostic categories:

1. Stroke;
2. Spinal cord injury;
3. Congenital deformity;
4. Amputation;
5. Major multiple trauma;
6. Fractures of femur;
7. Brain injury;
8. Burns;
9. Polyarthritis, including rheumatoid arthritis; and
10. Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease.

(p) To qualify for licensure as a rehabilitation hospital or rehabilitation unit located in a licensed health care facility, the following are required:

1. All staff shall have documented competencies in rehabilitation in accordance with facility policies;
2. A unit shall have a registered professional nurse assigned solely to each unit at all times; and
3. During each 24-hour period, at least 50 percent of all other licensed and unlicensed nursing personnel shall be individuals who are assigned solely to the rehabilitation service and who do not float from non-rehabilitation units or agencies.

Repeal and New Rule, R.2001 d.287, effective August 20, 2001.  
See: 32 N.J.R. 4073(a), 33 N.J.R. 2893(a).  
Section was "Surrender of license".

#### 8:43H-2.7 Surrender of license

(a) A rehabilitation hospital which intends to close voluntarily and to cease delivery of services shall notify the Department's Certificate of Need and Acute Care Licensure Program in writing a minimum of 30 days in advance. A plan for closure shall be developed which provides for the orderly transfer of patients to another rehabilitation hospital of their choice. Such plan shall also be submitted to the Department a minimum of 30 days prior to closure or cessation of service delivery.

(b) The rehabilitation hospital shall notify each patient, resident, or client, their physicians, 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 Department within seven working days after the voluntary surrender, non-renewal, or suspension of license.

Repeal and New Rule, R.2001 d.287, effective August 20, 2001.  
See: 32 N.J.R. 4073(a), 33 N.J.R. 2893(a).  
Section was "Waiver".

#### 8:43H-2.8 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of this chapter, waive sections of the rules if, in his or her opinion, such waiver would not endanger the life, safety, or health of patients or the public.

(b) A rehabilitation hospital seeking a waiver of these rules shall apply in writing to the Director of the Certificate of Need and Acute Care Licensure Program of the Department.

(c) A written request for waiver shall include the following:

1. The specific rule(s) or part(s) of the rule(s) for which waiver is requested;
2. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon full compliance;
3. An alternative proposal which would ensure patient safety; and
4. Documentation to support the application for waiver.

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

Repeal and New Rule, R.2001 d.287, effective August 20, 2001.  
See: 32 N.J.R. 4073(a), 33 N.J.R. 2893(a).  
Section was "Action against a license".