CHAPTER 43H

MANUAL OF STANDARDS FOR LICENSURE OF REHABILITATION HOSPITALS

Authority

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

Source and Effective Date

R.1994 d.367, effective June 17, 1994.
See: 26 N.J.R. 1628(a), 26 N.J.R. 2896(c).

Executive Order No. 66(1978) Expiration Date

Chapter 43H, Manual of Standards for Licensure of Rehabilitation Hospitals, expires on June 17, 1999.

Chapter Historical Note

Chapter 43H, Rehabilitation Hospitals, was filed and became effective August 21, 1989, as R.1989 d.432. See: 21 N.J.R. 1067(a), 21 N.J.R. 2476(b).

Subchapters 23 and 24 were filed and became effective August 21, 1989, as R.1989 d.433. See: 21 N.J.R. 1188(a), 21 N.J.R. 2494(a).

Pursuant to Executive Order No. 66(1978), Chapter 43H was readopted as R.1994 d.367. See: Source and Effective Date

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SUBCHAPTER 1. DEFINITIONS AND QUALIFICATIONS

8:43H–1.1 Scope

The rules in this chapter pertain to all facilities which provide comprehensive rehabilitation services, including hospitals which provide these services as a separate service. These rules constitute the basis for the licensure of rehabilitation hospitals by the New Jersey State Department of Health.

8:43H–1.2 Purpose

Rehabilitation hospitals provide integrated care to disabled individuals in order to assist these individuals in reaching the functional levels of which they are capable as well as to protect their health and safety. The aim of this chapter is to establish minimum rules to which a rehabilitation hospital must adhere in order to obtain a license to operate in New Jersey.

8:43H–1.3 Definitions

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

"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.

"Adult patient" means a patient who is 20 years of age or older.

"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.

"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 is an acceptable equivalent.

"Care plan" means a written plan of care for each patient, developed by each health care practitioner participating in the patient's care.

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

"Clinical note" means a written, signed, and dated notation made by each health care professional who renders a service to the patient.

"Commissioner" means the New Jersey State Commissioner of Health.

"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 patients 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.).

"Current" means up-to-date, extending to the present time.

"Department" means the New Jersey State Department of Health.

"Discharge plan" means a written plan initiated at the time of the patient's admission, which includes at least an evaluation of the patient's needs, the development of goals for discharge, and referrals to community agencies and resources for services following discharge.

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

"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 patient by an authorized person in accordance with all laws and rules governing such procedures.

"Drug dispensing" means a procedure entailing the interpretation of the original or direct copy of the prescriber's order for a drug and, pursuant to that order, the proper selection, measuring, labeling, packaging, and issuance of the drug to a patient or a service or unit of the facility, in conformance with all applicable Federal, State, and local rules and regulations.

"Environmental modification services" means a process of evaluation and/or adaptation of a patient's living environment as may be needed to permit maximum independent functioning.

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

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

"Full-time" means relating to a time period established by the facility as a full working week, as defined and specified in the facility's policies and procedures.

"Governing authority" means the organization, person, or persons designated to assume legal responsibility for the management, operation, and financial viability of the facility.

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

"Hospital" means a health care facility as defined in N.J.A.C. 8:43B.

"Intravenous infusion admixture service" means the preparation by pharmacy personnel of intravenous infusion solutions requiring compounding and/or reconstitution.

"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.

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

"Medical record" means all records in the facility which pertain to the patient, including radiological films.

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

"Multidisciplinary team" means those persons representing different services, who work together to provide an integrated program of care to the patient.

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

"Nursing unit" means a continuous area on one floor, which includes rooms for patients.

"Patient treatment plan" means a written plan of patient care which is based upon the patient assessments by the multidisciplinary team and care plans of all services participating in the patient's care.

"Pediatric patient" means a patient who is under 20 years of age.

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

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

"Rehabilitation hospital" means a facility licensed by the New Jersey State Department of Health to provide comprehensive rehabilitation services to patients for the alleviation or amelioration of the disabling effects of illness. Comprehensive rehabilitation services are characterized by the coordinated delivery of multidisciplinary care intended to achieve the goal of maximizing the self-sufficiency of the patient. A rehabilitation hospital is a facility licensed to provide only comprehensive rehabilitation services or is a distinct unit providing only comprehensive rehabilitation services located in a licensed health care facility.

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

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

"Sexual counseling services" means individual, family and/or group counseling regarding the individual patient and the effect of the specific disability on sexual function.

"Shift" means a time period defined as a full working day by the facility in its policy manual.

"Signature" means at least 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.

"Staff education plan" means a written plan developed at least annually and implemented throughout the year which describes a coordinated program for staff education for each service, including inservice 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 he or she 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.

1. "Direct supervision" means supervision on the premises within view of the supervisor.

"Unit dose drug distribution system" means a system in which drugs are delivered to patient areas in single unit packaging. Each patient has his or her own receptacle, such as a tray, bin, box, cassette, drawer, or compartment, labeled with his or her first and last name and room number, and containing his or her own medications. Each medication is individually wrapped and labeled with the generic name, trade name (if appropriate), and strength of the drug, lot number or reference code, expiration date, and manufacturer's or distributor's name, and ready for administration to the patient.

8:43H–1.4 Qualifications of the administrator of the rehabilitation hospital

The administrator shall have a baccalaureate degree in administration or in a health care discipline and four years of administrative or supervisory experience in a health care facility.

8:43H–1.5 Qualifications of audiologists

Each audiologist shall be so licensed by the Division of Consumer Affairs of the New Jersey State Department of Law and Public Safety.

8:43H–1.6 Qualifications of dentists

Each dentist shall be so licensed by the New Jersey State Board of Dentistry.

8:43H–1.7 Qualifications of dietitians

Each dietitian shall be registered or eligible for registration by the Commission on Dietetic Registration.

8:43H–1.8 Qualifications of the director of nursing services

The director of nursing services shall be a registered professional nurse who has completed a baccalaureate degree program accredited by the National League for Nursing and shall have at least two years of full-time, or full-time equivalent, experience in nursing supervision and/or nursing administration in a health care facility.

8:43H–1.9 Qualifications of food service supervisors

(a) Each food service supervisor shall:

1. Be a dietitian; or

2. Be a graduate of a dietetic technician or dietetic assistant training program approved by the American Dietetic Association; or

3. Be a graduate of a course, approved by the New Jersey State Department of Education, providing 90 or more hours of classroom instruction in food service supervision, and have one year of full-time, or full-time equivalent, experience as a food service supervisor in a health care facility, with consultation from a dietitian; or

4. Have training and experience in food service supervision and management in a military service equivalent to the programs listed in (a)2 or 3 above.

8:43H–1.10 Qualifications of licensed practical nurses

Each licensed practical nurse shall be so licensed by the New Jersey State Board of Nursing.

8:43H–1.11 Qualifications of the medical director

The medical director shall be a physiatrist who is certified by the American Board of Physical Medicine and Rehabilitation, Inc., or the American Osteopathic Board of Rehabilitation Medicine. If the facility provides services to pediatric patients only, the medical director may be a pediatrician who is certified by the American Board of Pediatrics, Inc., or the American Osteopathic Board of Pediatrics.

8:43H–1.12 Qualifications of medical record practitioners

(a) Each medical record practitioner shall:

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

2. Be 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 Medical Record Association.

8:43H–1.13 Qualifications of occupational therapists

Each occupational therapist shall be certified or eligible for certification as an occupational therapist, registered (OTR) by the American Occupational Therapy Association.

8:43H–1.14 Qualifications of pediatricians

Each pediatrician shall be a physician who is certified or eligible for certification by the American Board of Pediatrics, Inc., or the American Osteopathic Board of Pediatrics.

8:43H–1.15 Qualifications of pharmacists

Each pharmacist shall be so registered by the New Jersey State Board of Pharmacy.

8:43H–1.16 Qualifications of physiatrists

Each physiatrist shall be a physician who is certified or eligible for certification by the American Board of Physical Medicine and Rehabilitation, Inc., or the American Osteopathic Board of Rehabilitation Medicine.

8:43H–1.17 Qualifications of physical therapists

Each physical therapist shall be so licensed by the New Jersey State Board of Physical Therapy Examiners.

8:43H–1.18 Qualifications of physicians

Each physician shall be licensed or authorized by the New Jersey State Board of Medical Examiners to practice medicine in the State of New Jersey.

8:43H–1.19 Qualifications of psychologists

Each psychologist shall be so licensed by the New Jersey State Board of Psychological Examiners.

8:43H–1.20 Qualifications of recreational therapists

(a) Each recreational therapist shall:

1. Have a bachelor's degree from an accredited college with a major in recreation or therapeutic recreation; or

2. Have a bachelor's degree with a major in psychology, sociology, physical education, music, dance or drama including 18 semester hours of recreation or therapeutic recreation course content, and five years of full-time, or full-time equivalent, experience in therapeutic recreation.

8:43H–1.21 Qualifications of registered professional nurses

Each registered professional nurse shall be so licensed by the New Jersey State Board of Nursing.

8:43H–1.22 Qualifications of respiratory therapists

Each respiratory therapist shall be certified or eligible for certification by the National Board for Respiratory Care.

8:43H–1.23 Qualifications of social workers

(a) Each social worker shall:

1. Have a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education; or

2. Have a baccalaureate degree in social work from a social work program accredited by the Council on Social Work Education.

8:43H–1.24 Qualifications of speech-language pathologists

Each speech-language pathologist shall be so licensed by the Division of Consumer Affairs of the New Jersey State Department of Law and Public Safety.

SUBCHAPTER 2. LICENSURE PROCEDURES

8:43H–2.1 Certificate of Need

(a) According to N.J.S.A. 26:2H–1 et seq., and amendments thereto, a health care facility shall not be instituted, constructed, expanded, or licensed to operate except upon application for and receipt of a Certificate of Need issued by the Commissioner.

(b) Application forms for a Certificate of Need and instructions for completion may be obtained from:

Certificate of Need Program
Division of Health Planning and Resources Development
New Jersey State Department of Health
PO Box 360
Trenton, N.J. 08625–0360

(c) The facility shall implement all conditions imposed by the Commissioner as specified in the Certificate of Need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with N.J.S.A. 26:2H–1 et seq., and amendments thereto.

8:43H–2.2 Application for licensure

(a) Following receipt of a Certificate of Need as a rehabilitation hospital, any person, organization, or corporation desiring to operate a rehabilitation hospital shall make application to the Commissioner for a license on forms prescribed by the Department. Such forms may be obtained from:

Director
Licensing, Certification and Standards
Division of Health Facilities Evaluation
New Jersey State Department of Health
PO Box 367
Trenton, NJ 08625–0367

(b) The Department shall charge a nonrefundable fee of $8,000 for the filing of an application for licensure and each annual renewal as a rehabilitation hospital. These fees shall not exceed the maximum caps as set forth at N.J.S.A. 26:2H–12, as may be amended from time to time.

(c) The Department shall charge a nonrefundable fee of $1,000 for the filing of an application to add bed or non-bed related services to an existing rehabilitation hospital.

(d) The Department shall charge a nonrefundable fee of $250.00 for the filing of an application to reduce bed or non-bed related services at an existing rehabilitation hospital.

(e) The Department shall charge a nonrefundable fee of $1,000 for the filing of an application for the relocation of a rehabilitation hospital.

(f) The Department shall charge a nonrefundable fee of $2,000 for the filing of an application for the transfer of ownership of a rehabilitation hospital.

(g) Each applicant for a license to operate a facility shall make an appointment for a preliminary conference at the Department with the Licensing, Certification and Standards Program.

(h) Each rehabilitation hospital shall be assessed a biennial inspection fee of $4,000. 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 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.

Amended by R.1996 d.339, effective July 15, 1996.
See: 28 N.J.R. 2365(a), 28 N.J.R. 3556(a).
Amended by R.1998 d.579, effective December 7, 1998.

See: 30 N.J.R. 3633(a), 30 N.J.R. 4221(b).
In (b), increased the fee from $1,500 plus $5.00 per bed to $8,000 and deleted a former second sentence; and added (h).

8:43H–2.3 Newly constructed or expanded facilities

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

Health Facilities Construction Services
Division of Health Facilities Evaluation
New Jersey State Department of Health
PO Box 367
Trenton, N.J. 08625–0367

(b) An on-site inspection of the construction of the physical plant shall be made by representatives of the Health Facilities Construction Services to verify that the building has been constructed in accordance with the architectural plans approved by the Department.

(c) Any rehabilitation hospital with a construction program, whether a Certificate of Need is required or not, shall submit plans to the Health Facilities Construction Services of the Department for review and approval prior to the initiation of construction.

8:43H–2.4 Surveys and temporary license

(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 Health Facilities Inspection Program of the Department shall be conducted 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 Health Facilities Inspection Program of the Department when the deficiencies, if any, have been corrected, and the Health Facilities Inspection Program will schedule one or more resurveys of the facility prior to occupancy.

(b) A temporary license may be issued to a facility when the following conditions are met:

1. A preliminary conference (see N.J.A.C. 8:43H–2.2(c)) for review of the conditions for licensure and operation has taken place between the Licensing, Certification and Standards Program and representatives of the facility, who will be advised that the purpose of the temporary license is to allow the Department to determine the facility's compliance with N.J.S.A. 26:2H–1 et seq., and amendments thereto, and the rules pursuant thereto;

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

3. Written approvals of the water supply and sewage disposal system from local officials are on file with the Department for any water supply or sewage disposal system not connected to an approved municipal system;

4. Survey(s) by representatives of the Department indicate the facility adheres to the rules in this chapter; and

5. Professional personnel are employed in accordance with the staffing requirements in this chapter.

(c) No facility shall admit patients to the facility until the facility has the written approval and/or license issued by the Licensing, Certification and Standards Program of the Department.

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

(e) A temporary license may be issued to a facility for a period of six months and may be renewed as determined by the Department.

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

(g) The temporary license is not assignable or transferable and shall be immediately void if the facility ceases to operate or if its ownership changes.

8:43H–2.5 Full license

(a) A full license shall be issued on expiration of the temporary license, 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 amendments thereto, and by the rules 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 is not assignable or transferable, and it shall be immediately void if the facility ceases to operate or if its ownership changes.

(e) 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 facility will receive a request for renewal fee 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee is received by the Department.

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

8:43H–2.6 Surrender of license

The facility shall notify each patient, the patient'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 Licensing, Certification and Standards Program of the Department within seven working days after the voluntary surrender, revocation, non-renewal, or suspension of license.

8:43H–2.7 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 amendments thereto, and the rules in this chapter, waive sections of these rules if, in his or her opinion, such waiver would not endanger the life, safety, or health of patients or the public.

(b) A facility seeking a waiver of these rules shall apply in writing to the Director of the Licensing, Certification and Standards 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 adherence;

3. An alternative proposal which would ensure patient safety; and

4. Documentation to support the request for waiver.

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

8:43H–2.8 Action against a license

(a) If the Department determines that operational or safety deficiencies exist, it may require that all new admissions to the facility cease. This may be done simultaneously with, or in lieu of, action to revoke licensure and/or impose a fine. The Commissioner or his or her designee shall notify the facility in writing of such determination.

(b) The Commissioner may order the immediate removal of patients from a facility whenever he or she determines imminent danger to any person's health or safety.

(c) The provisions of this section shall apply to facilities with a temporary license and facilities with a full license.

8:43H–2.9 Hearings

(a) If the Department proposes to suspend, revoke, deny, 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 3. GENERAL REQUIREMENTS

8:43H–3.1 Services provided

(a) The facility shall provide preventive, diagnostic, therapeutic, and rehabilitative services to patients in accordance with the rules in this chapter.

(b) The facility shall provide, at a minimum, audiology, dental, dietary, driver evaluation, environmental modification, laboratory, medical, nursing, nutritional counseling, occupational therapy, orthotic and prosthetic, pharmaceutical, physiatry, physical therapy, psychological, radiological, recreational therapy, respiratory therapy, sexual counseling, social work, speech-language pathology, and vocational testing services directly in the facility.

(c) Driver training services shall be provided.

(d) Audiology, dental, driver evaluation, driver training, environmental modification, laboratory, medical, nursing, nutritional counseling, occupational therapy, orthotic and prosthetic, pharmaceutical, physiatry, physical therapy, psychological, radiological, recreational therapy, respiratory therapy, sexual counseling, social work, speech-language pathology, and vocational testing services shall be provided on an inpatient basis and on an outpatient basis.

(e) If a health care facility licensed by the Department provides comprehensive rehabilitation 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.

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

(g) The facility shall provide a minimum of three hours of services per patient per day, which shall include physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and/or audiology services, as specified in N.J.A.C. 8:43H–12.1(b) and (c).

8:43H–3.2 Ownership

(a) The ownership of the facility and the property on which it is located shall be disclosed to the Department. Proof of this ownership shall be available in the facility. Any proposed change in ownership shall be reported to the Director of the Licensing, Certification and Standards Program of the Department in writing at least 30 days prior to the change and in conformance with requirements for Certificate of Need applications.

(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.

8:43H–3.3 Submission and availability of documents

(a) The facility shall, upon request, submit in writing any documents which are required by the rules in this chapter to the Director of the Licensing, Certification and Standards Program of the Department.

8:43H–3.4 Personnel

(a) 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.

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

(c) The facility shall maintain written staffing schedules. Provision shall be made for substitute staff with equivalent qualifications to replace absent staff members. Staffing schedules shall be implemented to ensure continuity of care and the provision of services consistent with the rehabilitation goals specified in the patient treatment plan.

(d) 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 continuing in-service education regarding emergency plans and procedures, and the infection prevention and control services.

2. At least one education training program each year shall be held for all administrative and patient care staff regarding the rights and responsibilities of staff under the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H–53 et seq. (P.L. 1991, c.201), and the Federal Patient Self Determination Act (P.L. 101–508), and internal facility policies and procedures to implement these laws.

(e) At least one person trained in cardiopulmonary resuscitation in an approved course, as defined in the facility's policy and procedure manual, shall be in all patient areas when patients are present.

Amended by R.1992 d.133, effective March 16, 1992.
See: 23 N.J.R. 3214(a), 24 N.J.R. 945(a).
Staff training on advance directives required at (d)2.

8:43H–3.5 Policy and procedure manual

(a) 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 patient care services of the facility.

3. A description of the quality assurance program for patient care and staff performance;

4. Specification of business hours and visiting hours;

5. Policies and procedures for reporting all diagnosed and/or suspected cases of child abuse and/or neglect in compliance with N.J.S.A. 9:6–1 et seq.,[1] including, but not limited to, the following:

i. The designation of a staff member(s) to be responsible for coordinating the report of diagnosed and/or suspected cases of child abuse and/or neglect, recording the notification to the Division of Youth and Family Services on the medical record, and serving as a liaison between the facility and the Division of the Youth and Family Services;

[1] Copies of the law can be obtained from the local district office of the Division of Youth and Family Services (DYFS) or from the Office of Program Support, Division of Youth and Family Services, New Jersey State Department of Human Services, CN 717, Trenton, New Jersey 08625.

ii. The development of written protocols for the identification and treatment of abused and/or neglected children; and

iii. The provision of education and/or training programs to appropriate persons regarding the identification and reporting of diagnosed and/or suspected cases of child abuse and/or neglect and regarding the facility's policies and procedures on at least an annual basis;

6. Policies and procedures for the maintenance of confidential 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; and

7. Policies and procedures, including content and frequency, for physical examinations upon employment and subsequently for employees and persons providing direct patient care services through contractual arrangements or written agreements. Such policies and procedures shall ensure that;

i. Each employee who cannot document the result of a previous rubella screening test shall be given a rubella screening test using the rubella hemagglutination inhibition test or other rubella screening test approved by the Department. Each new employee who cannot document the result of a previous rubella screening test shall be given the rubella screening test upon employment. An employee who can document seropositivity from a previous rubella screening test or who can document inoculation with rubella vaccine shall not be required to have a rubella screening test;

(1) Each employee tested shall be informed in writing by the facility of the results of his or her rubella screening test;

(2) Each employee's personnel record shall contain documentation of all tests performed and the results; and

(3) A list shall be maintained of all employees who are seronegative and unvaccinated, to be used in the event that an employee is exposed to rubella and a determination is needed as to whether or not the employee may continue to work.

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

8:43H–3.6 Patient transportation

The facility shall develop and implement methods of patient transportation for services provided outside the facility, including emergency services, which includes plans for security and accountability for the patient and his or her personal possessions.

8:43H–3.7 Written agreements

The facility shall have a written agreement, or its equivalent, 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 require that services be provided in accordance with the rules in this chapter.

8:43H–3.8 Reportable events

(a) The facility shall notify the Department immediately by telephone at 609–588–7725 (609–392–2020 after business hours), followed within 72 hours by written confirmation, of the following:

1. Interruption or cessation of services listed in the rules in this chapter;

2. Termination of employment of the administrator, and the name and qualifications of the administrator's replacement;

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 patients and/or personnel, disruption of services, and extent of damages; and

5. All alleged or suspected crimes committed by or against patients, which shall also be reported at the time of occurrence to the local police department in accordance with Federal laws regarding confidentiality.

8:43H–3.9 Notices

(a) The facility shall conspicuously post a notice that the following information is available in the facility between 8:00 A.M. and 8:00 P.M. daily to patients and the public:

1. All waivers granted by the Department;

2. A 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 patient rights;

4. Visiting hours (including at least the time between the hours of 8:00 A.M. and 8:00 P.M. daily) and business hours of the facility, including the policies of the facility regarding limitations and activities during these times; and

5. The names and addresses of the members of the governing authority.

8:43H–3.10 Information reportable to State Board of Medical Examiners

(a) In compliance with N.J.S.A. 26:2H–12.2, the facility shall establish and implement written policies and procedures for reporting information to the New Jersey State Board of Medical Examiners in writing on forms provided by the Department, within 30 days of the proceeding or action, request, settlement, judgment or award. (Submit forms to the New Jersey State Board of Medical Examiners, 28 West State Street, Trenton, New Jersey 08608. Questions may be directed to the Board office at (609) 292–4843.) The information to be reported shall include, but not be limited to, the following:

1. A disciplinary proceeding or action taken by the governing body against any physician or surgeon licensed by the Board when the proceeding or action results in a physician's or surgeon's reduction or suspension of privileges or removal or resignation from the medical staff, including:

i. Name, professional degree, license number, and residence and/or office address of each physician or surgeon who was the subject of governing authority action which resulted in the reduction or suspension of privileges, or the removal or resignation of the physician or surgeon from the medical staff;

ii. Nature and grounds of proceedings;

iii. Date(s) of precipitating event(s) and of official action taken;

iv. Name, title, and telephone number of facility official(s) having knowledge of existence and location of pertinent records or persons familiar with the matter;

v. Pendency of any appeal; and

vi. Other information relating to the proceeding or action as may be requested by the Board; and

2. A medical malpractice liability insurance claim settlement, judgment or arbitration award in which the facility is involved, including:

i. Name, professional degree, license number, and residence and/or office address of each physician or surgeon who was involved in the medical malpractice liability insurance claim settlement, judgment or arbitration award;

ii. Nature and grounds of proceedings;

iii. Date(s) of precipitating event(s), and of official action taken;

iv. Name, title, and telephone number of facility official(s) having knowledge of the existence and location of pertinent records or persons familiar with the matter;

v. A copy of the complaint, response, and settlement order, judgment, or award; and

vi. Other information relating to the settlement, judgment, or arbitration award as may be required by the Board.

8:43H–3.11 Maintenance of records

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

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

2. Statistical data as required by the Department.

8:43H–3.12 Financial reports

(a) Upon development of a uniform cost reporting system approved by the Health Care Administration Board, the facility shall adopt and maintain the uniform system of cost reporting from which reports will be prepared to meet the requirements of the Commissioner as stated in N.J.S.A. 26:2H–1 et seq., and amendments thereto.

(b) An annual financial report shall be submitted to the Department and shall include a statement of income and expenditure.

SUBCHAPTER 4. GOVERNING AUTHORITY

8:43H–4.1 Responsibility of the governing authority

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

1. Services provided and the quality of care rendered to patients;

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

3. Adoption and documented review of written bylaws, or their equivalent, according to a schedule established by the governing authority;

4. Appointment, reappointment, assignment of privileges, and curtailment of privileges of health care professionals, and written confirmation of such actions;

5. Development and documented review of all policies and procedures, according to a schedule established by the governing authority;

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

7. Determination of the frequency of meetings of the governing authority and its committees, or their equivalents, conducting such meetings, and documenting them through minutes;

8. Delineation of the duties of the officers of any committees, or their equivalent, of the governing authority. When the governing authority establishes committees or their equivalents, their purpose, structure, responsibilities, and authority, and the relationship of the committee or its equivalent to other entities within the facility shall be documented;

9. Establishment of the qualifications of members and officers of the governing authority, the procedures for electing and appointing officers, and the terms of service for members, officers, and committee chairpersons or their equivalents; and

10. Approval of the medical staff bylaws or their equivalent.

SUBCHAPTER 5. ADMINISTRATION

8:43H–5.1 Appointment of administrator

The governing authority shall appoint a full-time administrator who shall be available on the premises of the facility at all times. An alternate shall be designated in writing to act in the absence of the administrator.

8:43H–5.2 Administrator's responsibilities

(a) 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 patient rights;

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

3. Participating in the quality assurance program for patient 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, communication, and integration with facility staff and services and with patients and their families.

8:43H–5.3 Advance directives; dispute resolution; forum for discussion; community education

(a) The facility shall establish procedures for considering disputes among the patient, the health care representative and the attending physician concerning the patient's decision-making capacity or the appropriate interpretation and application of the terms of an advance directive to the patient's course of treatment. The procedures may include consultation with an institutional ethics committee, a regional ethics committee or another type of affiliated ethics committee, or with any individual or individuals who are qualified by their background and/or experience to make clinical and ethical judgments.

(b) The facility shall establish a process for patients, families and staff to discuss and address questions and concerns relating to advance directives and decisions to accept or reject medical treatment.

(c) The facility shall provide periodic community education programs, individually or in coordination with other area facilities or organizations, that provide information to consumers regarding advance directives and their rights under New Jersey law to execute advance directives.

New Rule, R.1992 d.133, effective March 16, 1992.
See: 23 N.J.R. 3614(a), 24 N.J.R. 945(a).

8:43H–5.4 Policies and procedures for advance directives

(a) For purposes of this chapter, "advance directive" means a written statement of a patient's instructions and directions for health care in the event of future decision making incapacity, in accordance with the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H–53 et seq., (P.L. 1991, c.201). An advance directive may include a proxy directive, an instruction directive, or both.

(b) The facility shall develop and implement procedures to ensure that there is a routine inquiry made of each adult patient, upon admission to the facility and at other appropriate times, concerning the existence and location of an advance directive. If the patient is incapable of responding to this inquiry, the facility shall have procedures to request the information from the patient's family or, in the absence of a family member, another individual with personal knowledge of the patient. The procedures must assure that the patient or family's response to this inquiry is documented in the medical record. Such procedures shall also define the role of facility admissions, nursing, social service and other staff as well as the responsibilities of the attending physician.

(c) The facility shall develop and implement procedures to promptly request and take reasonable steps to obtain a copy of currently executed advance directives from all patients. These shall be entered when received into the medical record of the patient.

(d) A patient shall be transferred to another health care facility only for a valid medical reason, in order to comply with other applicable laws or Department rules, to comply with clearly expressed and documented patient choice, or in conformance with the New Jersey Advance Directives for Health Care Act in the instance of private, religiously affiliated health care institutions who establish policies defining circumstances in which it will decline to participate in the implementation of advance directives. Such institutions shall provide notice to patients or their families or health care representatives prior to or upon admission of their policies. A timely and respectful transfer of the individual to another institution which will implement the patient's advance directive shall be effected. The facility's inability to care for the patient shall be considered a valid medical reason. The sending facility shall receive approval from a physician and the receiving health care facility before transferring the patient.

(e) The facility shall, in consultation with the attending physician, take all reasonable steps to effect the appropriate, respectful and timely transfer of patients with advance directives to the care of an alternative health care professional in those instances where a health care professional declines as a matter of professional conscience to participate in withholding or withdrawing life-sustaining treatment. In those instances where the health care professional is the patient's physician, the facility shall take reasonable steps, in cooperation with the physician, to effect the transfer of the patient to another physician's care in a responsible and timely manner. Such transfer shall assure that the patient's advance directive is implemented in accordance with their wishes within the facility, except in cases governed by (d) above.

(f) The facility shall have procedures to provide each adult patient upon admission and, where the patient is unable to respond, to the family or other representative of the patient, with a written statement of their rights under New Jersey law to make decisions concerning the right to refuse medical care and the right to formulate an advance directive. Such statement shall be issued by the Commissioner. Appropriate written information and materials on advance directives and the institution's written policies and procedures concerning implementation of such rights shall also be provided. Such written information shall also be made available in any language which is spoken, as a primary language, by more than 10 percent of the population served by the facility.

(g) The facility shall develop and implement procedures for referral of patients requesting assistance in executing an advance directive or additional information to either staff or community resource persons that can promptly advise and/or assist the patient.

(h) The facility shall develop and implement policies to address application of the facility's procedures for advance directives to patients who experience an urgent life-threatening situation.

(i) The facility shall develop and implement policies and procedures for the declaration of death of patients, in instances where applicable, in accordance with N.J.S.A. 26:6 and the New Jersey Declaration of Death Act, N.J.S.A. 26:6A–1 et seq. (P.L. 1991, c.90). Such policies shall also be in conformance with rules promulgated by the New Jersey Board of Medical Examiners which address declaration of death based on neurological criteria, including the qualifications of physicians authorized to declare death based on neurological criteria and the acceptable medical criteria, tests, and procedures which may be used. The policies and procedures must also accommodate a patient's religious beliefs with respect to declaration of death.

New Rule, R.1992 d.133, effective March 16, 1992.
See: 23 N.J.R. 3614(a), 24 N.J.R. 945(a).

SUBCHAPTER 6. PATIENT CARE POLICIES

8:43H–6.1 Policies and procedures

(a) Written patient care policies and procedures 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. Patient rights;

2. The determination of staffing levels on the basis of patient need;

3. The referral of patients to other health care providers and medical consultative services. Medical consultative services shall include, at a minimum, the following: surgery, internal medicine, neurology, neurosurgery, ophthalmology, orthopedic surgery, otorhinolaryngology, pediatrics, plastic surgery, psychiatry, pulmonary medicine, and urology;

4. The provision of sexual counseling services directly in the facility, in accordance with the patient treatment plan;

5. The provision of environmental modification services in the patient's living environment, in accordance with the patient treatment plan;

6. Emergency care of patients, in accordance with the rules in this chapter; care of patients during an episode of communicable disease; and care of patients with tuberculosis which is not communicable following initiation of chemotherapy, or is nonpulmonary and therefore not transmissible;

7. Obtaining written informed consent;

8. Patient instruction and health education, including the provision of printed and/or written instructions and information for patients, with multilingual instructions as indicated;

9. Admission of patients;

10. An interview with the patient and his or her family, conducted by the administrator or his or her designee, prior to or at the time of the patient's admission. The interview shall include, at a minimum, orientation of the patient to the facility's policies, business hours, fee schedule, services provided, patient rights, and criteria for admission, treatment, and discharge. A summary of the interview shall be documented in the patient's medical record;

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

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

ii. A patient suffering from substance abuse or misuse only shall not be admitted to or retained in the facility; and

iii. If an applicant, after applying in writing, is denied admission to the facility, the applicant and/or his or her family shall be given the reason for such denial in writing, signed by the administrator, within 15 days;

12. Verbal and telephone orders, to ensure that they are written into the patient's medical record by the person accepting them and countersigned by the prescriber within 24 hours. Verbal and telephone orders shall be limited to emergency situations, as defined in the facility's policies and procedures;

13. Financial arrangements, to ensure that the facility:

i. Informs patients of the fees for services (where a fee is charged);

ii. Maintains a written record of all financial arrangements with the patient and/or his or her family, with copies furnished to the patient;

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

(1) Upon written approval and authority of the patient and/or his or her family, who shall be given a copy of the written approval;

(2) Upon written orders of the patient's physician, stipulating specific services and supplies not included in the admission agreement;

(3) Upon 15 days' prior written notice to the patient and/or his or her family of additional charges, expenses, or other financial liabilities due to the increased cost of maintenance and/or operation of the facility; or

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

iv. Describes for the patient agreements with third-party payors and/or other payors and referral systems for patients' financial assistance; and

v. Describes sliding fee scales and any special payment plans established by the facility;

14. Interpretation services, if the patient population is non-English-speaking or for patients who are blind or deaf;

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

16. Notification of the patient's family in the event that the patient sustains an injury, or an accident or incident occurs, immediately after the occurrence. Immediately following such notification, the notification shall be documented in the patient's medical record;

17. The use of restraints, including, as a minimum:

i. Specification of the uses of restraints and types of restraints permitted, specification of the frequency with which a patient placed in restraint shall be monitored and of the personnel responsible for monitoring the patient, and specification of the required documentation;

ii. Prohibition of the use of locked restraints and confinement of a patient in a locked or barricaded room, and prohibition of the use of restraints for punishment or for the convenience of facility personnel;

iii. Specification that restraints be used so as not to cause physical injury or discomfort to the patient and only when authorized for a specified period of time. Opportunity for motion and exercise shall be provided for a period of not less than 10 minutes during each one-hour period in which a physical restraint is employed, to ensure opportunity for elimination of body wastes, good body alignment, circulation, and change of position; and

iv. A requirement that a physical restraint be used only when authorized in writing by a physician except when necessitated by an emergency, in which case it shall be approved by the medical director, or the director of nursing services or his or her designee;

18. Discharge, transfer and readmission of patients, including criteria for each;

i. Written notification by the administrator shall be provided to a patient of a decision to involuntarily discharge him or her from the facility. The notice shall include the reason for discharge and the patient's right to appeal. A copy of the notice shall be entered in the patient's medical record;

ii. The patient 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 patient's medical record with the disposition or resolution of the appeal;

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

20. The calibration of instruments of measurement, including the frequency of calibration; and

21. Care of deceased patients, including, but not limited to, the following:

i. Pronouncement of death. The patient's family shall be notified at the time of death. The deceased shall not be discharged from the facility until pronounced dead and the death documented in the patient's medical record;

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

iii. Transportation of the deceased in the facility, and removal from the facility, in a dignified manner.

SUBCHAPTER 7. PATIENT ASSESSMENTS, CARE PLANS, AND TREATMENT PLAN

8:43H–7.1 Patient treatment plans

(a) Each patient shall have a written patient treatment plan, developed under the direction of a physician, which is based upon assessments of his or her needs by the multidisciplinary team.

1. The physician responsible for providing care to the patient shall document in the patient's medical record an admission and medical history and a report of physical examination within 24 hours of admission, the plan of care, and progress notes and shall participate as part of the multidisciplinary team in developing, implementing, reviewing, and revising the patient treatment plan.

2. A written plan of care shall be developed by the health care practitioners participating in the patient's care. The care plan shall include, but not be limited to: care to be provided based upon the patient assessment, an evaluation of the patient's potential for improving his or her functional level, goals consistent with the patient's potential for rehabilitation, and the patient's discharge plan. If the patient does not need a service, a care plan is not needed for that service.

3. The patient treatment plan shall be developed from the assessments by the multidisciplinary team and initiated upon the patient's admission. The patient treatment plan shall include, but not be limited to, the following:

i. Orders for treatment or services, medications, and diet;

ii. The patient's rehabilitation goals for himself or herself;

iii. The specific rehabilitation goals of treatment or services;

iv. The time intervals, which shall not exceed 14 days, at which the patient's response to treatment or services will be reviewed;

v. Anticipated time frame(s) for the accomplishment of the rehabilitation goals;

vi. The measures to be used to assess the effects of treatment or services.

(b) The patient and, if indicated, family members shall participate in the development of the patient treatment plan including the discharge plan. Participation shall be documented in the patient's medical record.

1. If, in the opinion of a physician, the patient's participation in the development of the patient treatment plan is medically contraindicated, as documented in the patient's medical record, a designated member of the multidisciplinary team shall review the treatment plan with the patient prior to implementation, and the family shall be informed of the treatment plan.

8:43H–7.2 Implementation of plans

(a) Each health care practitioner participating in the patient's care shall provide services in accordance with the care plan and patient treatment plan.

(b) Each health care practitioner providing services to the patient shall establish criteria to measure the effectiveness and outcome of services provided and shall assess and reassess the patient to determine if services provided meet the established criteria. Assessment and reassessment shall be documented in the patient medical record.

(c) Each health care practitioner providing services to the patient shall participate as a member of the multidisciplinary team in developing, implementing, reviewing and revising the patient treatment plan.

1. The multidisciplinary team shall review and revise the patient treatment plan based upon the patient's response to the care provided by each of the participating services. Documentation in the patient's medical record shall indicate review and revision of the patient treatment plan.

SUBCHAPTER 8. MEDICAL SERVICES

8:43H–8.1 Provision of medical services

Medical services shall be provided to all patients 24 hours a day, seven days a week, directly in the facility.

8:43H–8.2 Appointment of medical director

A full-time medical director shall be appointed. Comprehensive rehabilitation services shall be provided under the direction of the medical director. The medical director shall designate in writing a physician to act in his or her absence.

8:43H–8.3 Medical director's responsibilities

(a) The medical director shall be responsible for the direction, provision, and quality of medical services provided to patients. He or she shall be responsible for, but not limited to, the following:

1. Developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the medical service;

2. Participating in planning and budgeting for the medical service;

3. Coordinating and integrating the medical service with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for the medical staff, and assigning duties based upon education, training, competencies, and job descriptions; and

5. Developing, implementing, and reviewing written medical policies, including medical staff bylaws or their equivalent, in cooperation with the medical staff, including, but not limited to, the following:

i. A plan for medical staff meetings and their documentation through minutes;

ii. A mechanism for establishing and implementing procedures relating to credentials review, delineation of qualifications, medical staff appointments and reappointments, evaluation of medical care, and the granting, denial, curtailment, suspension, or revocation of medical staff privileges; and

iii. A system for completion of entries in the patient medical record by members of the medical staff. Entries shall be signed by a physician in accordance with the facility's policies and procedures.

8:43H–8.4 Responsibilities of physicians

The physician responsible for providing care to the patient shall document in the patient's medical record an admission and medical history and a report of physical examination within 24 hours of admission, the care plan,

and progress notes and shall participate as part of the multidisciplinary team in developing, implementing, reviewing, and revising the patient treatment plan.

8:43H–8.5 Availability of pediatrician

If the facility provides care for pediatric patients, a pediatrician shall be available.

8:43H–8.6 Availability of physiatrist

If the medical director of a facility providing services to pediatric patients is a pediatrician, a full-time physiatrist shall be available.

SUBCHAPTER 9. NURSING SERVICES

8:43H–9.1 Provision of nursing services

(a) The facility shall provide nursing services to patients 24 hours a day, seven days a week, directly in the facility.

(b) At least one registered professional nurse and one licensed nurse, excluding the director of nursing services or his or her designee, shall be assigned to each nursing unit 24 hours a day, seven days a week. Additional licensed nursing personnel and ancillary nursing personnel shall be provided in accordance with the facility's patient care policies and procedures for determining staffing levels on the basis of acuity of patient need.

(c) A registered professional nurse who has completed a baccalaureate degree program accredited by the National League for Nursing and who is certified by the Association of Rehabilitation Nurses shall provide staff orientation and staff education to nursing personnel.

8:43H–9.2 Appointment of director of nursing services

A registered professional nurse shall be appointed in writing as the director of nursing services and shall be on duty at all times. A registered professional nurse shall be designated in writing to act in the director's absence.

8:43H–9.3 Responsibilities of director of nursing services

(a) The director of nursing services shall be responsible for the direction, provision, and quality of nursing service provided to patients. He or she shall be responsible for, but not limited to, the following:

1. Developing and implementing written objectives, philosophy, policies, a procedure manual, an organizational plan, and a quality assurance program for the nursing service;

2. Participating in planning and budgeting for the nursing service;

3. Coordinating and integrating the nursing service with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for nursing and ancillary nursing personnel, and assigning duties based upon education, training, competencies, and job descriptions;

5. Ensuring that nursing services are provided to the patient as specified in the nursing care plan, which shall be initiated upon the patient's admission, and that nursing personnel are assigned to patients in accordance with the facility's patient care policies and procedures for determining staffing levels on the basis of acuity of patient need; and

6. Providing for a planned orientation program in rehabilitation nursing concepts.

8:43H–9.4 Responsibilities of licensed nursing personnel

(a) In accordance with the State of New Jersey Nursing Practice Act, N.J.S.A. 45:11–23 et seq., as interpreted by the New Jersey State Board of Nursing, and written job descriptions, licensed nursing personnel shall be responsible for providing nursing care, including, but not limited to, the following:

1. Care of patients through health promotion, maintenance, and restoration;

2. Care toward prevention of infection, accident, and injury;

3. Assessing the nursing care needs of the patient, preparing the nursing care plan based upon the assessment, providing nursing care services as specified in the nursing care plan, reassessing the patient's response to services provided, and revising the nursing care plan. Each of these activities shall be documented in the patient's medical record. A registered professional nurse shall assess the nursing needs of each patient, develop nursing diagnoses, and design the patient's plan of nursing care;

4. Teaching, supervising, and counseling the patient, family and staff regarding nursing care and the patient's needs. Only a registered professional nurse shall initiate these functions, which may be reinforced by licensed nursing personnel;

5. Participating as part of the multidisciplinary team in developing, implementing, reviewing, and revising the patient treatment plan;

6. Writing clinical notes and progress notes; and

7. Assisting the patient in activities of daily living based upon the patient's abilities, disabilities, and rehabilitation goals.

8:43H–9.5 Nursing care services related to pharmaceutical services

(a) Nursing personnel shall be responsible for, but not limited to, ensuring the following:

1. All drugs administered are prescribed in writing and the order signed and dated by the prescriber. Drugs shall be administered in accordance with all Federal and State laws and rules by the following licensed or authorized nursing personnel:

i. Registered professional nurses;

ii. Licensed practical nurses who are trained in drug administration in programs approved by the New Jersey State Board of Nursing;

iii. Nurses with a valid temporary work permit issued by the New Jersey State Board of Nursing; and

iv. Student nurses in a school of nursing approved by the New Jersey State Board of Nursing, under the supervision of a nurse faculty member;

2. Drugs are not prepoured. Drugs shall be administered promptly after the dose has been prepared, and by the individual who prepared the dose, except when a unit dose drug distribution system is used;

3. The patient is identified prior to drug administration. Drugs prescribed for one patient shall not be administered to another patient;

4. A record of drugs administered is maintained. After each drug administration, the following shall be documented by the nurse who administered the drug: name and strength of the drug, date and time of administration, dosage administered, method of administration, and signature of the nurse who administered the drug;

5. All drugs are kept in locked storage areas, except intravenous infusion solutions which shall be stored according to a system of accountability, as specified in the facility's policies and procedures. Drug storage and preparation areas shall be kept locked when not in use. Drugs requiring refrigeration shall be kept in a separate, locked box in the refrigerator, in a locked refrigerator, or in a refrigerator in the locked medication room. The refrigerator shall have a thermometer to indicate temperature in conformance with U.S.P. (United States Pharmacopoeia) requirements;

6. Needles and syringes are procured, stored, used, and disposed of in accordance with the laws of the State of New Jersey and amendments thereto. There shall be a system of accountability for the disposal of used needles and syringes which shall not necessitate the counting of individual needles and syringes after they are placed in the container for disposal; and

7. Drugs are stored and verified according to the following:

i. Drugs in Schedules III and IV of the Controlled Dangerous Substances Acts and amendments thereto shall be stored under lock and key. Drugs in Schedule II of the Controlled Dangerous Substances Acts and amendments thereto shall be stored in a separate, locked, permanently affixed compartment within the locked medication cabinet, medication room, refrigerator, or mobile medication cart. The key to the separate, locked compartment for Schedule II drugs shall not be the same key that is used to gain access to storage areas for other drugs (except that drugs in Schedule II in a unit dose drug distribution system shall be kept under double lock and key, but may be stored with other controlled drugs);

ii. The keys for the storage compartments for drugs in Schedules II, III, and IV shall be kept on a person who meets the criteria listed in (a)1i through iv above; and

iii. Except in a unit dose drug distribution system, a declining inventory of all drugs in Schedule II of the Controlled Dangerous Substances Acts and amendments thereto shall be made at the termination of each tour of duty wherever these drugs are maintained. This record shall be signed by both the outgoing and incoming nurses who shall meet the criteria listed in (a)1i through iv above. The following shall be recorded: name of the patient receiving the drug, prescriber's name, name and strength of the drug, date received from the pharmacy, date of administration, dosage administered, method of administration, signature of the licensed nurse who administered the drug, amount of drug remaining, amount of drug destroyed or wasted (when appropriate), and the signature of the nurse who witnessed the destruction or wasting of the drug (when appropriate).

SUBCHAPTER 10. PHARMACEUTICAL SERVICES

8:43H–10.1 Provision of pharmaceutical services

Pharmaceutical services shall be provided to patients 24 hours a day, seven days a week, directly in the facility. If the facility has an institutional pharmacy, the pharmacy shall be licensed by the New Jersey State Board of Pharmacy and operated in accordance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and shall possess a current Drug Enforcement Administration registration and a Controlled Dangerous Substance registration from the Department in accordance with the Controlled Dangerous Substances Acts.

8:43H–10.2 Appointment of pharmacist

(a) A pharmacist shall be appointed and shall be responsible for the direction, provision, and quality of the pharma-

ceutical services. The pharmacist shall be responsible for, but not limited to, the following:

1. Together with the Pharmacy and Therapeutics Committee, developing and maintaining written objectives, policies, and a procedure manual, an organizational plan, and a quality assurance program for the pharmaceutical service;

2. Participating in planning and budgeting for the pharmaceutical service;

3. Coordinating and integrating the pharmaceutical service with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for pharmacy personnel, if any, and assigning duties based upon education, training, competencies, and job descriptions;

5. Participating as part of the multidisciplinary team in developing, implementing, reviewing, and revising the patient treatment plan;

6. Maintaining a means of identifying the signatures of all prescribers authorized to use the pharmaceutical service for prescriptions; and

7. Maintaining records of the transactions of the pharmaceutical service, as required by Federal, State, and local laws, to ensure control and accountability of all drugs. This shall include a system of controls and records for the requisitioning and dispensing of pharmaceutical supplies to all services of the facility.

8:43H–10.3 Pharmacy and Therapeutics Committee

(a) A multidisciplinary Pharmacy and Therapeutics Committee shall be appointed by and accountable to the governing authority. The committee shall be responsible for, but not limited to, the following:

1. Development of policies and procedures, approved by the governing authority, and documentation of their review. These policies and procedures shall govern evaluation, selection, obtaining, dispensing, storage, distribution, administration, use, control, accountability, and safe practices pertaining to all drugs used in the treatment of patients;

2. Development and at least annual review and approval of a current formulary ("Formulary" means a list of all drugs approved for use in the facility. It may also list drugs which are considered appropriate for treating specific illnesses, or may list substitutions of chemically or therapeutically equivalent drugs for trade name prescription drugs.); and

3. Approval of the minimal pharmaceutical reference materials to be retained at each nursing unit, those to be kept in the pharmacy and made available to at least nursing personnel and the medical staff, and methods for communicating product information to at least nursing personnel and the medical staff.

8:43H–10.4 Policies and procedures for drug administration

(a) The facility's policies and procedures shall ensure that the right drug is administered to the right patient in the right amount through the right route of administration and at the right time. Policies and procedures shall include, but not be limited to, the following:

1. Policies and procedures for the implementation of a unit dose drug distribution system;

i. The facility shall have a unit dose drug distribution system. ("Unit dose drug distribution system" means a system in which drugs are delivered to patient areas in single unit packaging. Each patient has his or her own receptacle, such as a tray, bin, box, cassette, drawer, or compartment, labeled with his or her first and last name and room number, and containing his or her own medications. Each medication is individually wrapped and labeled with the generic name, trade name (if appropriate), and strength of the drug, lot number or reference code, expiration date, and manufacturer's or distributor's name, and ready for administration to the patient.) At least one exchange of patient medications shall occur every three days. The number of doses for each patient shall be sufficient for a maximum of 72 hours. No more than a 72–hour supply of doses shall be delivered to or available in the patient care area at any time;

ii. Cautionary instructions and additional information, such as special times of administration, regarding dispensed medications shall be transmitted to the personnel responsible for the administration of the medications;

iii. If the facility repackages medications in single unit packages, the facility's policies and procedures shall indicate how such packages shall be labeled to identify the lot number or reference code and manufacturer's or distributor's name; and

iv. Policies and procedures shall specify the drugs which will not be obtained from manufacturers or distributors in single unit packages and will not be repackaged as single units in the facility;

2. Methods for procuring drugs on a routine basis, in emergencies, and in the event of disaster;

3. Policies and procedures, approved by the Pharmacy and Therapeutics Committee in accordance with these rules, regarding emergency kits and emergency carts, including the following:

i. Approval of their locations and contents;

ii. Provision for pediatric doses in areas of the facility where pediatric emergencies may occur;

iii. Determination of the frequency of checking contents, including expiration dates;

iv. Approval of the assignment of responsibility for checking contents; and

v. A requirement that emergency kits are secure but are not kept under lock and key;

4. Policies and procedures, approved by the medical staff of the facility, to ensure that all drugs are ordered in writing, that the written order specifies the name of the drug, dose, frequency, and route of administration, that the order is signed and dated by the prescriber, and that all drugs are administered in accordance with the laws of the State of New Jersey;

5. Policies and procedures for drug administration, including, but not limited to, establishment of the times for administration of drugs prescribed;

6. If facility policy permits, policies and procedures regarding self-administration of drugs. ("Self-administration" means a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a patient to himself or herself.) Policies and procedures for self-administration shall include, but not be limited to, the following:

i. A requirement that self-administration be permitted only upon a written order of the prescriber;

ii. Storage of drugs;

iii. Labeling of drugs;

iv. Methods for documentation in the patient's medical record of self-administered drugs;

v. Training and education of patients in self-administration and the safe use of drugs; and

vi. Establishment of precautions so that patients do not share their drugs or take the drugs of another patient;

7. Policies and procedures for documenting and reviewing adverse drug reactions and medication errors. Allergies shall be documented in the patient's medical record and on its outside front cover;

8. Policies and procedures for ensuring the immediate delivery of stat. doses. Stat. (statim) shall mean immediately;

9. If facility policy permits, policies and procedures for the use of floor stock drugs. "Floor stock" means a supply of drugs provided by the pharmacist to a service or unit in a labeled container in limited quantities, as approved by the Pharmacy and Therapeutics Committee of the facility. A list shall be maintained of floor stock drugs and their amounts stored throughout the facility;

10. Policies and procedures for discontinuing drug orders, including, but not limited to, the following:

i. The length of time drug orders may be in effect, for drugs not specifically limited as to duration of use or number of doses when ordered, including intravenous infusion solutions; and

ii. Notification of the prescriber by specified personnel and within a specified period of time prior to the expiration of a drug order to ensure that the drug is discontinued if no specific renewal is ordered;

11. Policies and procedures for the use of intravenous infusion solutions. The facility shall have an intravenous infusion admixture service operated by the pharmaceutical service. If the preparation, sterilization, and labeling of parenteral medications and solutions are performed in the exempt areas within the facility, as specified by facility policy, but not under direct supervision of a pharmacist, the pharmacist shall be responsible for providing written guidelines and for approving the procedures. Policies and procedures for the use of intravenous infusion solutions shall include, but not be limited to, the following:

i. Safety measures for the preparation, sterilization, and admixture of intravenous infusion solutions. These shall be prepared under a laminar air flow hood, except in patient care areas specified by facility policy;

ii. Quality control procedures for laminar air flow hoods, including cleaning of the equipment used on each shift, microbiological monitoring as required by the infection prevention and control policies and procedures of the facility, and documented checks at least every 12 months for operational efficiency; and

iii. Policies and procedures for the labeling of intravenous infusion solutions, such that a supplementary label is affixed to the container of any intravenous infusion solution to which drugs are added. The label shall include the patient's first and last name and room number; the name of the solution; the name and amount of the drug(s) added; the date and time of the addition; the date, time, and rate of administration; the name or initials of the pharmacy personnel who prepared the admixture; the name, initials, or identifying code of the pharmacist who prepared or supervised preparation of the admixture; supplemental instructions, including storage requirements; and the expiration date of the solution;

12. Policies and procedures for the storage of intravenous infusion solutions, which shall be stored according to a system of accountability specified in the facility's policies and procedures;

13. If facility policy permits, policies and procedures for drug research and the use of investigational drugs, in accordance with Federal and State rules and regulations;

14. Policies and procedures regarding the purchase, storage, safeguarding, accountability, use, and disposition of drugs, in accordance with New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and the Controlled Dangerous Substances Acts and amendments thereto;

15. Policies and procedures for the procurement, storage, use, and disposition of needles and syringes in accordance with the laws of the State of New Jersey and amendments thereto. There shall be a system of accountability for the purchase, storage, and distribution of needles and syringes. There shall be a system of accountability for the disposal of used needles and syringes which shall not necessitate the counting of individual needles and syringes after they are placed in the container for disposal;

16. Policies and procedures regarding the control of drugs subject to the Controlled Dangerous Substances Acts and amendments thereto, in compliance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and all other Federal and State laws and regulations concerning procurement, storage, dispensing, administration, and disposition. Such policies and procedures shall include, but not be limited to, the following:

i. Provision for a verifiable record system for controlled drugs;

ii. Policies and procedures to be followed in the event that the inventories of controlled drugs cannot be verified or drugs are lost, contaminated, unintentionally wasted, or destroyed. A report of any such incident shall be written and signed by the persons involved and any witnesses present; and

iii. In all areas of the facility where drugs are dispensed, administered, or stored, procedures for the intentional wasting of controlled drugs, including the disposition of partial doses, and for documentation which includes the signature of a second person who shall witness the disposition;

17. Policies and procedures for the maintenance of records of prescribers' Drug Enforcement Administration numbers for New Jersey;

18. Specification of the information on drugs, their indications, contraindications, actions, reactions, interactions, cautions, precautions, toxicity, and dosage, to be provided in the pharmacy and in each nursing unit. Current antidote information and the telephone number of the regional poison control center shall also be provided in the pharmacy and in each nursing unit;

19. A list of abbreviations, metric apothecary conversion charts, and chemical symbols, approved by the medical staff, to be kept in each nursing unit; and

20. Policies and procedures concerning the activities of medical and pharmaceutical sales representatives in the facility. Drug samples shall not be accepted, placed or maintained in stock, distributed, or used in the facility.

8:43H–10.5 Inspection of premises

At intervals specified in the policy and procedure manual, a pharmacist shall inspect all areas in the facility where drugs are dispensed, administered, or stored, and shall maintain record of such inspections.

8:43H–10.6 Storage of drugs

(a) All drugs, except intravenous infusion solutions, shall be kept in locked storage areas. Drug storage and preparation areas shall be kept locked when not in use.

(b) All drugs shall be stored in accordance with manufacturers' instructions. Drugs requiring refrigeration shall be kept in a separate, locked box in the refrigerator, in a locked refrigerator, or in a refrigerator in the locked medication room, at or near the nursing unit. The refrigerator shall have a thermometer to indicate temperature in conformance with U.S.P. (United States Pharmacopoeia) requirements.

(c) All drugs in Schedule II of the Controlled Dangerous Substances Acts and amendments thereto shall be stored in a separate, locked, permanently affixed compartment within the locked medication cabinet, medication room, refrigerator, or mobile medication cart. The key to the separate, locked compartment for Schedule II drugs shall not be the same key that is used to gain access to storage areas for other drugs.

(d) Drugs for external use shall be kept separate from drugs for internal use.

SUBCHAPTER 11. DIETARY SERVICES

8:43H–11.1 Provision of dietary services

The facility shall provide dietary services to meet the daily nutritional needs of patients, directly in the facility.

8:43H–11.2 Appointment of dietitian

(a) The facility shall appoint a full-time dietitian who shall be responsible for the direction, provision, and quality of the dietary service. The dietitian shall be responsible for, but not limited to, the following:

1. Developing and implementing written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the dietary service;

2. Participating in planning and budgeting for the dietary service;

3. Ensuring that dietary services are provided as specified in the dietary care plan and are coordinated with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for dietary personnel, and assigning duties based upon education, training, competencies, and job descriptions; and

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

6. Providing nutritional counseling.

8:43H–11.3 Food service supervisor

The facility shall appoint a full-time food service supervisor who functions under the direction of a dietitian. A dietitian and/or food service supervisor shall be on duty seven days a week.

8:43H–11.4 Responsibilities of dietitians

(a) In accordance with written job descriptions, dietitians shall be responsible for providing dietary care, including, but not limited to, the following:

1. Assessing the dietary needs of the patient, preparing the dietary care plan based on the assessment, providing dietary services to the patient as specified in the dietary care plan, reassessing the patient's response to services, and revising the dietary care plan. Each of these activities shall be documented in the patient's medical record;

2. Participating as part of the multidisciplinary team in developing, implementing, reviewing, and revising the patient treatment plan;

3. Writing clinical notes and progress notes; and

4. Assisting the patient in activities of daily living based upon the patient's abilities, disabilities, and rehabilitation goals.

8:43H–11.5 Requirements for dietary services

(a) Dietary personnel shall be scheduled for a period of at least 12 hours daily.

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

(c) A current diet manual shall be available in the dietary service and in each nursing unit.

(d) Meal planning shall be 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 patients;

2. Written, dated menus shall be planned at least 14 days in advance of all diets. The same menu shall not be used more than once in seven days; and

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

(e) Meal preparation and serving shall be in accordance with, but not limited to, the following:

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

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

3. At least three meals or their equivalent shall be prepared and served daily to patients. At least two meals shall contain three or more menu items, one of which shall be or shall include a high quality protein food such as meat, fish, eggs, or cheese. Each meal shall represent no less than 20 percent of the day's total calories, and at least 10 percent of the day's total calories shall be provided by protein;

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

5. Between-meal and bedtime nourishments shall be provided and beverages shall be available at all times for each patient, unless contraindicated by a physician as documented in the patient's medical record;

6. Substitute foods and beverages of equivalent nutritional value shall be available to all patients;

7. No more than 14 hours shall elapse between an evening meal and breakfast the next morning; and

8. Designated staff shall be responsible for observing meals refused or missed and documenting the name of the patient and the meal refused or missed.

(f) A record shall be maintained for each patient, identifying the patient by name, location, diet order, and other information, such as meal patterns when on a calculated diet, and allergies. Such record shall appear on the patient's tray or in the dining room.

SUBCHAPTER 12. PHYSICAL THERAPY, OCCUPATIONAL THERAPY, RESPIRATORY THERAPY, SPEECH–LANGUAGE PATHOLOGY, AND AUDIOLOGY SERVICES

8:43H–12.1 Provision of physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology services

(a) The facility shall provide physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology services directly in the facility to meet the rehabilitation needs of patients.

(b) The facility shall provide to each adult patient at least three hours of services per day, five days per week, which shall include physical therapy and shall include at least one of the following: occupational therapy and/or speech-language pathology services.

(c) The facility shall provide to each pediatric patient at least three hours of services per day, five days per week, which shall include at least two of the following: physical therapy, occupational therapy, speech-language pathology, and respiratory therapy services.

8:43H–12.2 Appointment of physical therapist, occupational therapist, respiratory therapist, speech-language pathologist, and audiologist

(a) The facility shall appoint a physical therapist, occupational therapist, respiratory therapist, speech-language pathologist, and audiologist who shall be responsible for the direction, provision, and quality of the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology service, respectively. The physical therapist, occupational therapist, respiratory therapist, speech-language pathologist, and audiologist shall be responsible for, but not limited to, the following:

1. Developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology service, respectively;

2. Participating in planning and budgeting for the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology service, respectively;

3. Ensuring that services are provided as specified in the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology care plan, respectively, and are coordinated with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology personnel, respectively, and assigning duties based upon education, training, competencies, and job descriptions; and

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

8:43H–12.3 Responsibilities of physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology personnel

(a) In accordance with the State of New Jersey Physical Therapy Practice Act, N.J.S.A. 45:9–37.11 et seq., for physical therapy personnel, and in accordance with the State of New Jersey Audiology and Speech–Language Pathology Practice Act, N.J.S.A. 45:3B–1 et seq., for speech-language pathology and audiology personnel, and in accordance with written job descriptions, each physical therapist, occupational therapist, respiratory therapist, speech-language pathologist, or audiologist shall be responsible for providing patient care, including, but not limited to, the following:

1. Assessing the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, or audiology needs, respectively, of the patient, preparing the care plan based on the assessment, providing services as specified in the physical therapy, occupational therapy, respiratory therapy, speech-language pathology, or audiology care plan, respectively, reassessing the patient's response to services, and revising the care plan. Each of these activities shall be documented in the patient's medical record;

2. Participating as part of the multidisciplinary team in developing, implementing, reviewing, and revising the patient treatment plan;

3. Writing clinical notes and progress notes; and

4. Assisting the patient in activities of daily living based upon the patient's abilities, disabilities, and rehabilitation goals.

SUBCHAPTER 13. SOCIAL WORK SERVICES AND PSYCHOLOGY SERVICES

8:43H–13.1 Provision of social work services and psychology services

The facility shall provide social work services and psychology services to patients directly in the facility.

8:43H–13.2 Appointment of social worker and psychologist

(a) The facility shall appoint a full-time social worker who has a master's degree in social work, and a psychologist. The social worker and the psychologist shall be responsible for the direction, provision, and quality of the social work service and psychology service, respectively. The social worker and the psychologist shall be responsible for, but not limited to, the following:

1. Developing and implementing written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the social work service and psychology service, respectively;

2. Participating in planning and budgeting for the social work service and psychology service, respectively;

3. Ensuring that services are provided as specified in the social work care plan and psychology care plan, respectively, and are coordinated with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for social work service personnel and psychology service personnel, respectively, and assigning duties based upon education, training, competencies, and job descriptions; and

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

8:43H–13.3 Responsibilities of social worker and psychology staff

(a) In accordance with written job descriptions, each social worker or psychology staff member shall be responsible for providing patient care, including, but not limited to, the following:

1. Assessing the social work needs or psychological needs, respectively, of the patient, preparing the social work care plan or psychology care plan, respectively, based on the assessment, providing services as specified in the social work care plan or psychology care plan, respectively, reassessing the patient's response to services, and revising the social work care plan or psychology care plan, respectively. Each of these activities shall be documented in the patient's medical record;

2. Participating as part of the multidisciplinary team in developing, implementing, reviewing, and revising the patient treatment plan; and

3. Writing clinical notes and progress notes.

SUBCHAPTER 14. RECREATIONAL THERAPY SERVICES

8:43H–14.1 Provision of recreational therapy services

(a) The facility shall provide recreational therapy services to patients. A planned, diversified program of recreational activities for patients, including daytime, evening, individual, group, and/or independent activities, on at least six days of the week, directly in the facility.

(b) Patients shall have the opportunity to communicate with members of the community, to participate in community activities, and to utilize community resources, unless contraindicated by the patient's physician as documented in the patient's medical record.

(c) Indoor and outdoor recreation shall be provided.

8:43H–14.2 Appointment of recreation therapist

(a) The facility shall appoint a recreation therapist who shall be responsible for the direction, provision, and quality of the recreational therapy service. The recreation therapist shall be responsible for, but not limited to, the following:

1. Developing and implementing written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the recreational therapy service;

2. Participating in planning and budgeting for the recreational therapy service;

3. Ensuring that services are provided as specified in the recreational therapy care plan and are coordinated with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for recreational therapy personnel, and assigning duties based upon education, training, competencies, and job descriptions;

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

6. Posting a current weekly recreational activities schedule where it can be read by patients, staff, and visitors, and maintaining a record of such schedules for one year.

8:43H–14.3 Responsibilities of recreation therapy personnel

(a) In accordance with written job descriptions, each recreation therapist shall be responsible for providing patient care, including, but not limited to, the following:

1. Assessing the recreational therapy needs of the patient, preparing the recreational therapy care plan based on the assessment, providing recreational therapy services as specified in the recreational therapy care plan, reassessing the patient's response to services, and revising the recreational therapy care plan. Each of these activities shall be documented in the patient's medical record;

2. Participating as part of the multidisciplinary team in developing, implementing, reviewing, and revising the patient treatment plan;

3. Writing clinical notes and progress notes; and

4. Assisting the patient in activities of daily living based upon the patient's abilities, disabilities, and rehabilitation goals.

SUBCHAPTER 15. ORTHOTIC AND PROSTHETIC SERVICES, VOCATIONAL TESTING, DRIVER TRAINING SERVICES, DENTAL SERVICES, LABORATORY AND RADIOLOGICAL SERVICES

8:43H–15.1 Provision of services

(a) The facility shall provide orthotic and prosthetic services, vocational testing, dental services, and laboratory and radiological services directly in the facility to patients who need these services.

(b) Driver training services shall be provided.

8:43H–15.2 Qualifications of personnel

(a) Orthotic and prosthetic services shall be provided by persons certified or eligible for certification by the American Board for Certification in Orthotics and Prosthetics, Inc.

(b) Vocational testing services shall be provided by a rehabilitation counselor who is certified or eligible for certification by the Commission on Rehabilitation Counselor Certification.

(c) Driver training services shall be provided by persons licensed as commercial driving school instructors by the New Jersey State Department of Law and Public Safety, Division of Motor Vehicles.

8:43H–15.3 Provision of dental services

(a) Dental services shall be provided to patients, including, but not limited to, emergency dental care to relieve pain and infection.

(b) The facility, with consultation from a dentist, shall establish and implement written policies and procedures for dental services for patients and for staff education regarding dental care of patients.

(c) The dentist shall document in the patient's medical record all dental services provided, at the time services are provided.

8:43H–15.4 Provision of laboratory and radiological services

(a) Laboratory services shall be provided. Laboratories shall be licensed or approved by the Department.

(b) Radiological services shall be provided. Facilities providing radiological services shall be licensed or approved by the New Jersey State Department of Environmental Protection, Bureau of Radiation Protection.

SUBCHAPTER 16. EMERGENCY SERVICES AND PROCEDURES

8:43H–16.1 Emergency plans and procedures

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

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

(c) The emergency plans and all emergency procedures shall be conspicuously posted throughout the facility. Personnel shall be trained in the location and use of emergency equipment in the facility.

8:43H–16.2 Drills and tests

(a) Simulated drills of emergency plans shall be conducted on each shift at least four times a year (a total of 12 drills) and documented, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The four drills on each shift 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.

(b) The facility shall test at least one manual pull alarm each week of the year and maintain documentation of test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition.

(c) Fire extinguishers shall be examined annually and maintained in accordance with manufacturers' and National Fire Protection Association (N.F.P.A.) requirements.

SUBCHAPTER 17. PATIENT RIGHTS

8:43H–17.1 Policies and procedures regarding patient rights

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

(b) The staff of the facility shall be trained to implement policies and procedures regarding patient rights.

(c) The facility shall comply with all applicable State and Federal statutes and rules concerning patient rights, including N.J.S.A. 52:27G–7.1. The State Office of the Ombudsman for the Institutionalized Elderly shall be notified of any suspected patient abuse or exploitation pursuant to N.J.S.A. 52:27G–7.1, if the patient is 60 years of age or older.

8:43H–17.2 Rights of each patient

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

1. Is informed of these rights, as evidenced by his or her written acknowledgement, and receives an explanation, in terms that he or she can understand, and a copy of the patient rights;

2. Is informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for his or her care, and 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 informed of the plan for treatment and of his or her condition, unless medically contraindicated as documented by a physician in the patient's medical record, is informed of the risks associated with the use of any drugs and/or procedures, and has the opportunity to participate in the planning of his or her treatment, to refuse medication and treatment, and to 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, to comply with clearly expressed and documented patient choice, or in conformance with the New Jersey Advance Directives for Health Care Act, as specified in N.J.A.C. 8:43H–5.4(d), or for his or her welfare or that of other patients, upon the written order of the patient's physician, and such actions are documented in the patient's medical record, except in an emergency situation, in which the administrator shall notify the physician and the family immediately, and document the reason for the transfer in the patient's medical record. If a transfer or discharge on a nonemergency basis is requested by the facility, including transfer or discharge for nonpayment for the patient's stay (except as prohibited by sources of third party payment), the patient and his or her family shall be given at least 10 days advance notice of such transfer or discharge;

6. Has access to and/or may obtain a copy of his or her medical record, in accordance with the facility's policies and procedures and with applicable Federal and State laws and rules;

7. Is free from mental and physical abuse, free from exploitation, and free from the use of chemical and physical restraints, except those restraints used in accordance with N.J.A.C. 8:43H–6.1(a)17. Drugs and other medications shall not be used for punishment or for convenience of facility personnel;

8. Is assured confidential treatment of his or her records and disclosures in accordance with State and Federal statutes and rules, and shall have the opportunity to approve or refuse their release to any individual outside the facility, except in the case of the patient'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 his or her dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy and confidentiality concerning patient treatment and disclosures. Privacy of the patient's body shall be maintained during the toileting, bathing, and other activities of personal hygiene, except as needed for patient safety or assistance;

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

11. May associate and communicate privately with persons of his or her choice, may join with other patients or individuals within or outside the facility to work for improvements in patient care, may send and receive personal mail unopened, and, upon his or her request, shall be given assistance in the reading and writing of correspondence;

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

13. Is allowed to leave the facility if his or her physician so approves and so indicates in the patient's medical record. A signout sheet shall record the patient's whereabouts at these times;

14. Is assured security in retaining and using personal clothing and possessions as space permits, unless to do so would be unsafe or would infringe upon rights of other patients. If the patient has property on deposit with the facility, he or she shall have daily access to such property during specific periods established by the facility;

15. Is allowed daily visitation at least between the hours of 8:00 A.M. and 8:00 P.M. and, if critically ill, is allowed visits from his or her family at any time, unless medically contraindicated (as documented, by a physician, in the patient's medical record). The facility shall conspicuously post the visiting hours, which shall include at least the time between the hours of 8:00 A.M. and 8:00 P.M. daily. Members of the clergy shall be notified by the facility at the patient's request and shall be admitted at the request of the patient and/or family at any time. Privacy shall be ensured for visits with family, friends, clergy, or for professional or business purposes;

16. Is allowed to conduct private telephone conversations between the hours of 8:00 A.M. and 8:00 P.M. daily;

17. Is not required to go to bed unless ordered by a physician, with documentation in the patient's medical record;

18. 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 patient;

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

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

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

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

Division of Health Facilities Evaluation
New Jersey State Department of Health
CN 367
Trenton, New Jersey 08625
Telephone: (800) 792–9770

and

State of New Jersey
Office of the Ombudsman for the Institutionalized Elderly
CN 808
Trenton, New Jersey 08625
Telephone: (800) 624–4262

(c) The administrator shall also provide all patients and/or their families with the name, addresses, and telephone numbers of the following office where information concerning Medicare coverage may be obtained:

Legal Assistance for Medicare Patients
c/o The Community Health Law Project
530 Cooper Street
Camden, New Jersey 08102
Telephone: (609) 964–0030

or

7 Glenwood Avenue
East Orange, New Jersey 07017
Telephone: (201) 672–6073

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

Amended by R.1992 d.133, effective March 16, 1992.
See: 23 N.J.R. 3614(a), 24 N.J.R. 945(a).
Text on patient choice added at (a)5.

SUBCHAPTER 18. DISCHARGE PLANNING SERVICES

8:43H–18.1 Discharge plan

(a) The facility plan shall provide discharge planning services to patients.

(b) Each patient shall have a discharge plan. Discharge planning shall be initiated upon admission. Plans for discharge shall be reviewed and revised.

(c) The patient and, if indicated, family members shall participate in developing and implementing the patient discharge plan. Participation shall be documented in the patient medical record.

(d) The discharge plan shall include instructions given to the patient and/or his or her family for care following discharge.

8:43H–18.2 Discharge planning policies and procedures

(a) Written policies and procedures shall be established and implemented for discharge planning services, which shall describe:

1. The functions of the person or persons responsible for planning, providing, and/or coordinating discharge planning services;

2. The time period for completing each patient's discharge plan;

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

4. Use of the multidisciplinary team in discharge planning;

5. Criteria for patient discharge; and

6. Methods of patient and family involvement in developing and implementing the discharge plan.

Case Notes

Parents had no counterclaim against hospital under the Consumer Fraud Act for hospital's alleged improper practices in supposedly coercing son to remain in the hospital after need for treatment had ended for purposes of inflating hospital's gross income receipts. Hampton Hosp. v. Bresan, 288 N.J.Super. 372, 672 A.2d 725 (A.D. 1996).

SUBCHAPTER 19. MEDICAL RECORDS

8:43H–19.1 Maintenance of medical records

(a) A current medical record shall be maintained for each patient 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 patient's complete medical record is filed as one unit in one location within the facility.

8:43H–19.2 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.

8:43H–19.3 Contents of medical records

(a) The patient medical record shall include, but not be limited to, the following:

1. Patient identification data, including name, date of admission, address, date of birth, race and 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;

2. The patient's signed acknowledgement that he or she has been informed of and given a copy of patient rights;

3. A summary of the admission interview;

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

5. A patient treatment plan, signed and dated by the physician;

6. Care plans and patient assessments for each service providing care to the patient;

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

8. Progress notes;

9. Documentation of the patient's participation in his or her treatment plan, or documentation by a physician that the patient's participation is medically contraindicated;

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 patient self-administers medications, in accordance with the facility's policies and procedures;

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

13. Documentation of sexual counseling and environmental modification services;

14. Documentation of orthotic and prosthetic services, vocational testing, driver training, laboratory and radiological, and dental services;

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

16. Documentation of consultations;

17. A record of the clothing, personal effects, valuables, funds, and other property deposited by the patient with the facility for safekeeping, signed by the patient or his or her family, and substantiated by receipts given to the patient or his or her family;

18. Any signed written informed consent forms;

19. Documentation of the existence, or nonexistence, of an advance directive and the facility's inquiry of the patient concerning this;

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

21. Documentation of injuries, accidents, incidents, or death;

22. The discharge plan; and

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

Amended by R.1992 d.133, effective March 16, 1992.
See: 23 N.J.R. 3614(a), 24 N.J.R. 945(a).
Text on documentation of advance directives added at (a)19.

8:43H–19.4 Requirements for entries

(a) All orders for patient care shall be prescribed in writing and signed and dated by the prescriber, in accordance with the laws of the State of New Jersey.

(b) All entries in the patient medical record shall be legible and signed and dated by the person entering them.

8:43H–19.5 Medical records policies and procedures

(a) The facility shall establish and implement written policies and procedures regarding medical records including, but not limited to, policies and procedures for the following:

1. The protection of medical record information against loss, tampering, alteration, destruction, or unauthorized use. The patient's consent shall be obtained for release of medical record information;

2. The specific period of time in which the medical record shall be completed following patient discharge, and disciplinary action for noncompliance;

3. The transfer of patient information when the patient is transferred to another health care facility, or if the patient becomes an outpatient at the same facility, including a copy of the patient's advance directive, if available, or notice that the patient has informed the sending facility of the existence of an advance directive; and

4. The release and/or provision of copies of the patient's medical record to the patient and/or the patient's authorized representative. Such written policies and procedures shall include, but not be limited to, the following:

i. Establishment of a fee schedule for obtaining copies of the patient's medical record;

ii. Policies and procedures regarding patient access to his or her medical record during business hours;

iii. Policies and procedures regarding availability of the patient's medical record to the patient's authorized representative if it is medically contraindicated (as documented by a physician in the patient's medical record) for the patient to have access to or obtain copies of the record; and

iv. Procedures to ensure that the patient's medical record is provided within 30 calendar days of the written request.

Amended by R.1992 d.133, effective March 16, 1992.
See: 23 N.J.R. 3614(a), 24 N.J.R. 945(a).
Text on documentation of advance directives added at (a)3.

8:43H–19.6 Preservation, storage, and retrieval of medical records

(a) All medical records shall be preserved in accordance with N.J.S.A. 26:8–5 et seq.

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

SUBCHAPTER 20. INFECTION PREVENTION AND CONTROL SERVICES

8:43H–20.1 Administrator's responsibility

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

8:43H–20.2 Infection control policies and procedures

(a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures regarding the following:

1. A definition of nosocomial infection;

2. In accordance with N.J.A.C. 8:57, 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 patients or personnel having these infections, diseases, or conditions;

3. Reporting of reportable and other diseases in accordance with N.J.A.C. 8:57;

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

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

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

7. The prevention of decubitus ulcers;

8. Isolation of patients, including criteria for isolation;

9. Sterilization, disinfection, and cleaning 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 non-disposable patient care items. Disposable items shall not be reused;

iii. Methods to ensure that sterilized materials are packaged and labeled 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; and

10. The collection, storage, handling, and disposition of all pathological and infectious wastes within the facility, and for the collection, storage, handling, and disposition of all pathological and infectious wastes to be removed from the facility, including, but not limited to, the following:

i. Needles and syringes shall be destroyed in accordance with N.J.S.A. 2A:170–25.17, and amendments thereto;

ii. Solid, sharp, or rigid items shall be placed in a puncture-resistive container and incinerated or compacted prior to disposal;

iii. Non-rigid items, such as blood tubing and disposable equipment and supplies, shall be incinerated or placed in three mil plastic bags or equivalent and disposed of in a sanitary landfill approved by the New Jersey State Department of Environmental Protection;

iv. Fecal matter and liquid waste, such as blood and blood products, shall be flushed into the sewerage system; and

v. All pathology specimens and waste, including gross and microscopic tissue removed surgically or by any other procedure, shall be incinerated.

(b) Each service in the facility shall develop written policies and procedures for the infection control program for that service.

8:43H–20.3 Staff orientation and education

All personnel shall receive orientation at the time of employment and continuing in-service education regarding the infection control program.

SUBCHAPTER 21. HOUSEKEEPING, SANITATION, AND SAFETY

8:43H–21.1 Provision of services

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

(b) The facility shall provide housekeeping, laundry, 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.

8:43H–21.2 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.

8:43H–21.3 Patient care 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 patient 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 contamination 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, insects, vermin, and birds out of the facility;

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

18. Solid or liquid waste, garbage, and trash shall be stored or disposed of in accordance with the rules of the New Jersey State Department of Environmental Protection and the New Jersey State Department of Health. Solid waste shall be stored in insectproof, rodentproof, fireproof, nonabsorbent, watertight containers with tight-fitting covers. 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. Draperies, upholstery, and other fabrics or decorations shall be fire-resistant and flameproof;

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

21. Latex foam pillows shall be prohibited;

22. The temperature of the hot water used for showers, bathing and handwashing shall not exceed 110 degrees Fahrenheit (43 degrees Celsius); and

23. The temperature in the facility shall be kept at a minimum of 72 degrees Fahrenheit (22 degrees Celsius) during the day and at a minimum of 68 degrees Fahrenheit (20 degrees Celsius) at night. "Day" shall mean the time between sunrise and sunset.

8:43H–21.4 Linen and laundry services

(a) Written policies and procedures shall be established and implemented for linen and laundry services, including, but not limited to, policies and procedures regarding the following:

1. The storage, transportation and laundering of linen and personal laundry. Such policies shall not interfere with the patient's right to personal choice regarding dress;

2. The frequency of laundering linen and personal laundry;

3. The frequency of changing bed linen, towels, and washcloths;

4. Provision of a supply of linen, including at least sheets, pillow cases, blankets, drawsheets (or an alternative), towels, and washcloths, that is three times the licensed bed capacity, so that at least one set of clean linens remains available for each patient;

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

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

7. Protection of clean linen from contamination during processing, transporting, and storage.

SUBCHAPTER 22. QUALITY ASSURANCE PROGRAM

8:43H–22.1 Quality assurance plan

The facility shall establish and implement a written plan for a quality assurance program for patient 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 patient care services.

8:43H–22.2 Quality assurance activities

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

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

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

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

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

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

6. Establishment of a patient care outcome assessment system for evaluation of the patient care provided by each service, which includes criteria to be used for the determination of achievement of patient rehabilitation goals. The assessment of outcome shall examine the condition of the patient at the conclusion of care in relation to the goals of the patient's treatment.

8:43H–22.3 Measures for corrections and improvements

The results of the quality assurance program shall be submitted to the governing authority at least annually and shall include at least deficiencies found and recommendations for corrections or improvements. Deficiencies which jeopardize patient safety shall be reported to the governing authority immediately. The administrator shall, with the approval of the governing authority, implement measures to ensure that corrections or improvements are made.

SUBCHAPTER 23. PHYSICAL PLANT

8:43H–23.1 Standard for construction, alteration, or renovation of rehabilitation facilities

(a) Standards for construction of rehabilitation facilities in new buildings, additions, alterations and renovations to existing buildings shall be in accordance with the New Jersey Uniform Construction Code, N.J.A.C. 5:23 under Use Group I–2 and standards imposed by the United States Department of Health and Human Services (HHS), the New Jersey Departments of Health and Community Affairs, and the Guidelines for Construction and Equipment of Hospital and Medical Facilities 1987 Edition as published by The American Institute of Architects Press. In order to avoid conflict between N.J.A.C. 5:23 and the other standards listed above, Sections 501.3, 610.4.1, 704.0, 705.0, 706.0, 708.0 and 916.5 of the 1987 BOCA Basic Building Code of the New Jersey Uniform Construction Code shall not govern with respect to health care facilities.

(b) The following standards, in addition to those in (a) above, shall apply to alterations and renovations of existing buildings.

1. When alterations and/or renovations are made within any 12 month period, costing in excess of 50 percent of the physical value of the structure, requirements for new structures shall apply to entire structure, including those portions not altered or renovated.

2. When alterations and/or renovations are made within any 12 month period, costing between 25 percent to 50 percent of the physical value of the structure, only the altered or renovated areas need to conform to the requirements for new structures.

3. When alterations and/or renovations are made within any 12 month period costing less than 25 percent of the physical value of the structure, the New Jersey Department of Health shall determine to what degree the portions so altered or renovated shall be made to conform to the requirements for new structures.

SUBCHAPTER 24. FUNCTIONAL REQUIREMENTS

8:43H–24.1 Provisions for the handicapped

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

8:43H–24.2 Functional service areas

(a) Each rehabilitation facility shall contain the following service areas on site:

1. Medical evaluation services;
2. A psychology service with sexual counseling services;
3. Social work services;
4. Vocational services;
5. Recreation therapy services;
6. Respiratory therapy services;
7. Dietary services with nutritional counseling;
8. Administration services;
9. Nursing services;
10. Physical therapy services;
11. Occupational therapy services with environmental modification services, driver evaluation services and activities of daily living services;
12. Orthotic and prosthetic services;
13. Speech-language pathology and audiology services;
14. Dental services;
15. Radiology services;
16. Laboratory services;
17. Pharmacy services;
18. Sterilization services;
19. Linen services;
20. Housekeeping services;
21. Employees facilities;
22. Engineering service and equipment areas; and
23. Educational services.

(b) The following optional special service areas may be provided, if required by the program.

1. Urology services; and
2. Personal care services.

(c) Each rehabilitation facility shall also comply with the requirements for details and finishes set forth at N.J.A.C. 8:43H–24.26 and 24.27.

8:43H–24.3 Medical evaluation services

(a) The medical evaluation service shall include the following:

1. Office(s) for personnel;

2. Examination rooms, which shall have a minimum floor area of 120 square feet, excluding such spaces as the vestibule, toilet, closet, and work counter (whether fixed or movable). The minimum room dimension shall be 10 feet. The room shall contain a lavatory or sink equipped for handwashing, a work counter, storage facilities and a desk, counter, or shelf space for writing; and

3. Evaluation room areas, which shall be arranged to permit appropriate evaluation of patient needs and progress and to determine specific programs of rehabilitation. Rooms shall include a desk and work area for the evaluators; writing and workspace for patients; and storage for supplies. Where the facility is small and the workload light, evaluation may be done in the examination room(s).

8:43H–24.4 Psychology services

The psychology services unit shall include offices and workspace for testing, evaluation and counseling.

8:43H–24.5 Social work services

The social work services unit shall include office space(s) for private interviewing and counseling, waiting space, record storage space and secretarial office space.

8:43H–24.6 Vocational services

The vocational services unit shall contain office(s) and workspace for evaluation, counseling and placement.

8:43H–24.7 Patient dining, recreation therapy and day spaces

(a) Patient dining, recreation therapy and day spaces may be in separate or adjoining spaces and it shall be possible for both dining and recreation to occur simultaneously.

(b) For inpatients and residents, a total of 30 square feet per bed for the first 100 beds and 27 square feet per bed for all beds in excess of 100 shall be provided for patient dining, recreation therapy and day spaces.

(c) An indoor and an outdoor recreation area shall be provided.

(d) For outpatients in medical day and/or day hospitalization, a total of 20 square feet per person shall be provided, if dining is part of the day care program. If dining is not part of the program, at least 10 square feet per person for recreation and day spaces shall be provided.

(e) Storage spaces shall be provided for recreational equipment and supplies.

(f) An office for the recreation therapist shall be provided.

8:43H–24.8 Respiratory therapy services

(a) Respiratory therapy services may be provided as a separate area or at the patient's bedside.

1. A separate area shall include:

i. Office and clerical space;

ii. Convenient access to staff toilets, lounge, lockers and showers;

iii. A conference room;

iv. Storage for equipment and supplies; and

v. Space and utilities for cleaning and sanitizing equipment.

2. If respiratory therapy services are provided at the patient's bedside, there shall be storage in the patient's room for equipment and supplies.

8:43H–24.9 Dietary services and nutritional counseling

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

1. A control station for receiving food supplies;

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

3. Food preparation facilities as follows:

i. Conventional food preparation systems with space and equipment for preparing, cooking, and baking;

ii. Convenience food service systems; 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. Patient meal service facilities for tray assembly and distribution;

6. Dining space for staff and visitors;

7. Warewashing space, which shall be located in a room or an alcove separate from food preparation and serving area. Commercial dishwashing equipment shall be provided. Space shall also be provided for receiving, scraping, sorting, and stacking soiled tableware and separate area for transferring clean tableware to the using areas. A lavatory shall be conveniently available;

8. Potwashing facility(ies);

9. Storage areas for cans, carts, and mobile tray conveyors;

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

11. Office(s) or desk space(s) for dietitian(s) or the dietary service manager;

12. Toilets for dietary staff with handwashing facility(ies), which shall be immediately available;

13. A janitor's closet located within the dietary department and containing a floor receptor or service sink and storage space for housekeeping equipment and supplies; and

14. Self-dispensing icemaking facilities, which may be in an area or room separate from the food preparation area, but must be easily cleanable and convenient to dietary facilities.

(b) Nutritional counseling shall be provided in the dietitian's office, or conference room or patient bedroom, based on program.

8:43H–24.10 Administration services

(a) A grade-level entrance, sheltered from the weather and able to accommodate wheelchairs, shall be provided which conforms to the requirements of N.J.A.C. 5:23–7.

(b) A lobby shall be provided which shall include:

1. Wheelchair storage space(s);
2. A reception and information counter or desk;
3. Waiting space(s);
4. Public toilet facility(ies);
5. Public telephone(s); and
6. Drinking fountain(s).

(c) Interview space(s) for private interviews relating to social service, credit, and admissions shall be provided.

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

(e) Multipurpose room(s) shall be provided for conferences, meetings, health education, and library services.

(f) Special storage shall be provided for employees' personal effects.

(g) Separate space for office supplies, sterile supplies, pharmaceutical supplies, splints and other orthopedic supplies, and housekeeping supplies and equipment shall be provided.

8:43H–24.11 Nursing services

(a) The maximum size of an adult unit or pediatric unit shall be 30 beds.

(b) Each patient room shall meet the following requirements:

1. Maximum room occupancy shall be four patients. At least two single-bed rooms with private toilet rooms shall be provided for each nursing unit.

2. Each patient shall have a minimum room area exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules of 125 square feet in single-bed rooms and 100 square feet per bed in multi-bed rooms.

3. Each bedroom shall have a space for a wheelchair to make a 180 degree turn, which is a clear space of 60 inches in diameter.

4. Each one-bed room shall have a minimum clear floor space of 36 inches along each side of bed and 42 inches between the foot of the bed and the wall.

5. Each two-bed room shall have a minimum clear floor space of 42 inches between the foot of bed and the wall, 36 inches between the side of bed and the wall and 48 inches between beds.

6. Each four-bed room shall have a minimum clear floor space of 48 inches from the foot of the bed to the foot of the opposing bed, 36 inches between side of bed and the wall and 48 inches between beds.

7. Each patient sleeping room shall have a window.

8. A nurses' calling system shall be provided as follows:

i. Each patient room shall be served by at least one calling station for two way voice communications;

ii. Each bed shall be provided with a call button;

iii. Two call buttons serving adjacent beds may be served by one calling station;

iv. Calls shall activate a visible signal in the corridor at the patient's door; and

v. Nurses' call emergency system shall be provided at each inpatient toilet, bath, sitz bath and shower room. The call system shall be designed so that a signal light activated at the calling patients' station will remain lighted until turned off at the patients' calling station.

9. In new construction, handwashing facilities shall be provided in each patient room. In renovations and modernization, the lavatory may be omitted from the bedroom where a water closet and lavatory are provided in a toilet room designed to serve one single-bed room, or one two-bed room.

10. Each patient shall have access to a toilet room without having to enter the general corridor area. One toilet room shall serve no more than four beds and no more than two patient rooms. The toilet room shall contain a water closet and a lavatory. The lavatory may be omitted from a toilet room that serves single-bed and two-bed rooms if each such patient's room contains a lavatory.

11. Each patient shall have a wardrobe, closet, or locker with minimum clear dimensions of one foot 10 inches by one foot eight inches, suitable for hanging full-length garments. A clothes rod and adjustable shelf shall be provided.

12. Visual privacy shall be provided for each patient in multi-bed rooms with cubicle curtains between beds.

(c) The service areas noted below shall be in or readily available to each nursing unit. Although identifiable spaces are required for each indicated function, consideration will be given to alternative designs that accommodate some functions without designating specific areas or rooms. Each service area may be arranged and located to serve more than one nursing unit, but at least one such service area shall be provided on each nursing floor. The following service areas shall be provided:

1. An administrative center or nurses' station;
2. A nurses' office;
3. Storage for administrative supplies;

4. Handwashing facilities located near the nurses' station and the drug distribution station. One lavatory may serve both areas;

5. Charting facilities for staff;

6. A lounge and toilet room(s) for staff;

7. Individual closets or compartments for safekeeping the personal effects of nursing personnel, located convenient to the duty station or in a central location;

8. A room for examination and treatment of patients. This room may be omitted if all patient rooms are single-bed rooms. It shall have a minimum floor area of 120 square feet, excluding space for vestibules, toilet, closets, and work counters (whether fixed or movable). The minimum room dimension shall be 10 feet. The room shall contain a lavatory or sink equipped for handwashing, work counter, storage facilities, and a desk, examination table, counter, or shelf space for writing. The examination room in the evaluation unit may be used if it is in the immediate area;

9. A clean workroom or clean holding room;

10. A soiled workroom or soiled holding room;

11. A drug distribution station. Provisions shall be made for convenient and prompt 24–hour distribution of medicine to patients. Distribution may be from a medicine preparation room, a self-contained medicine dispensing unit, or through another approved system. If used, a medicine preparation room shall be under the nursing staff's visual control and contain a work counter, refrigerator, and locked storage for biologicals and drugs. A medicine dispensing unit may be located at a nurses' station, in the clean workroom, or in an alcove or other space under visual observation of nursing or pharmacy staff;

12. Clean linen storage with a separate closet or an area within the clean workroom provided for this purpose. If a closed-cart system is used, storage may be in an alcove;

13. A nourishment station, which shall contain a sink for handwashing, equipment for serving nourishment between scheduled meals, a refrigerator, storage cabinets, and icemaker-dispenser units;

14. An equipment storage room for equipment such as I.V. stands, inhalators, air mattresses, and walkers; and

15. Parking for stretchers and wheelchairs which shall be located out of the path of normal traffic.

(d) Bathtubs or showers shall be provided at a ratio of one bathing facility for each eight beds not otherwise served by bathing facilities within patient rooms. At least one island-type bathtub shall be provided in each nursing unit. Each tub or shower shall be in an individual room or privacy enclosure that provides space for the private use of bathing fixtures, for drying and dressing, and for a wheelchair and an assistant. Showers in central bathing facilities shall be at least four feet square, curb-free, and designed for use by a wheelchair patient.

(e) Patient toilet facilities shall be as follows:

1. The minimum dimensions of a room containing only a toilet shall be three feet by six feet clear space; additional space shall be provided if a lavatory is located within the same room. Toilets must be usable by wheelchair patients;

2. At least one room on each floor containing a nursing unit(s) shall be provided for toilet training. It shall be accessible from the corridor. A minimum clearance of three feet shall be provided at the front and at each side of the toilet. This room shall also contain a lavatory;

3. A toilet room that does not require travel through the general corridor shall be accessible to each central bathing area;

4. Doors to toilet rooms shall have a minimum width of two feet 10 inches to admit a wheelchair. The doors shall permit access from the outside in case of an emergency and swing outward; and

5. A handwashing facility shall be provided for each water closet in each multifixture toilet room.

8:43H–24.12 Physical therapy services

(a) The following shall be provided in physical therapy services:

1. Office space;

2. Waiting space;

3. Treatment area(s);

i. For thermotherapy, diathermy, ultrasonics, respiratory therapy, hydrotherapy, and other treatments performed in a physical therapy unit, cubicle curtains around each individual treatment area shall be provided. Handwashing facility(ies) shall also be provided. One lavatory or sink may serve more than one cubicle. Facilities for collection of wet and soiled linen and other material shall be provided.

4. An exercise area;

5. Storage for clean linen, supplies, and equipment;

6. Patients dressing areas, showers, lockers, and toilet rooms; and

7. Wheelchair and stretcher storage.

(b) The areas designated in (a)1, 2, 5, 6 and 7 above may be planned and arranged for shared use by occupational therapy patients and staff if the functional program reflects this sharing concept.

8:43H–24.13 Occupational therapy services

(a) The following shall be provided in an occupational therapy service unit:

1. Office space;

2. Waiting space;

3. Activity areas, which shall have provisions for a sink or lavatory;

4. Storage for supplies and equipment;

5. Patients dressing areas, showers, lockers, and toilet rooms;

6. Space for driver evaluation;

7. An environmental modification area (bio-engineering rehabilitation therapy); and

8. Activities for daily living.

i. An area for teaching the activities of daily living shall be provided. The area shall include a bedroom, bath, and kitchen space with stove.

(b) The areas designated in (a)1, 2, 4, 5 and 8 above may be planned and arranged for shared use by physical therapy patients and staff, if the functional program reflects this sharing concept.

8:43H–24.14 Prosthetics and orthotics services

(a) The following shall be provided in a prosthetic and orthotic service:

1. Workspace for technician(s);

2. Space for evaluation and fitting which shall include provision for privacy; and

3. Space for equipment, supplies, and storage.

8:43H–24.15 Speech-language pathology and audiology services

(a) The following shall be provided in speech-language pathology and audiology services:

1. Office(s) for therapists;

2. Space for evaluation and treatment; and

3. Space for equipment and storage.

8:43H–24.16 Dental services

(a) A dental unit shall contain a dental chair with light and drill, and lavatory.

(b) If the program does not require a room, a portable chair may be used.

8:43H–24.17 Radiology services

(a) A radiology service shall contain the following:

1. Radiographic room(s);

2. Film processing facilities;

3. Viewing and administration area(s);

4. Film storage facilities;

5. A toilet room with handwashing facility;

6. Dressing area(s) conveniently accessible to toilets;

7. A waiting area; and

8. A holding area for stretcher patients.

(b) A portable x-ray with film processing facilities may be used, if required by program.

8:43H–24.18 Laboratory services

(a) Laboratory services shall be provided within the rehabilitation hospital or through contract arrangement with a hospital or laboratory service for hematology, clinical chemistry, urinalysis, cytology, pathology, and bacteriology.

1. If laboratory services are provided on-site the following shall be the minimum provided:

i. Laboratory work counter(s) with a sink, and gas and electric service;

ii. Handwashing facilities;

iii. Storage cabinet(s) or closet(s);

iv. Specimen collection facilities. Urine collection rooms shall be equipped with a water closet and lavatory. Blood collection facilities shall have space for a chair and work counter; and

v. Refrigerator.

8:43H–24.19 Pharmacy services

(a) Pharmacy services shall be provided within the rehabilitation hospital or through a contract.

1. If pharmacy services are provided on-site, the following shall be the minimum provided.

i. A dispensing area with handwashing facility;

ii. An area for compounding; and

iii. Locked storage areas.

8:43H–24.20 Sterilization services

Where required by the functional program, a system for sterilizing equipment and supplies shall be provided.

8:43H–24.21 Linen services

(a) If linen is to be processed on the site, the following shall be provided:

1. A laundry processing room with commercial equipment that can process seven days' laundry within a regularly scheduled workweek, with handwashing facilities;

2. A soiled linen receiving, holding, and sorting room with handwashing and cart-washing facilities;

3. Storage for laundry supplies;

4. A clean linen 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 the rehabilitation facility site, the following shall be provided:

1. A soiled linen holding room; and

2. A clean linen receiving, holding, inspection, and storage room(s).

8:43H–24.22 Housekeeping services

A janitor's closet shall be provided for each nursing unit. It may service two nursing units if they are on the same floor and adjacent to each other. In addition, janitor's closets shall be provided throughout the facility as required to maintain a clean and sanitary environment.

8:43H–24.23 Employees facilities

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

8:43H–24.24 Engineering service and equipment areas

(a) Equipment room(s) for boilers, mechanical equipment, and electrical equipment shall be provided.

(b) Storage rooms for building maintenance supplies and yard equipment shall be provided.

(c) Space and facilities shall be provided for the sanitary storage and disposal of waste. If provided, design and construction of incinerators and trash chutes shall conform to the requirements prescribed by the New Jersey Department of Environmental Protection.

8:43H–24.25 Educational services

Space shall be provided for educational services. In a pediatric unit, there shall be classroom(s) for pediatric patients as required by the New Jersey Department of Education.

8:43H–24.26 Details

(a) Compartmentation, exits, automatic extinguishing systems, and other details relating to fire prevention and fire protection in inpatient rehabilitation facilities shall comply with requirements listed in the New Jersey Uniform Construction Code, N.J.A.C. 5:23.

(b) Items such as drinking fountains, telephone booths, vending machines and portable equipment shall not restrict corridor traffic or reduce the corridor width below the required minimum.

(c) Rooms containing bathtubs, sitz baths, showers, and water closets which are subject to patient use shall be equipped with doors and hardware that will permit access from the outside in an emergency. When such rooms have only one opening, the doors shall open outward or be otherwise designed to open without pressing against a patient who may have collapsed within the room.

(d) Minimum width of all doors to rooms needing access for beds shall be three feet eight inches. Doors to rooms requiring access for stretchers and doors to patient toilet rooms and other rooms needing access for wheelchairs shall have a minimum width of two feet 10 inches. Where the functional program states that the sleeping facility will be for residential use (and therefore not subject to in-bed patient transport), patient room doors may be three feet wide, if approved by the New Jersey Department of Health.

(e) Doors between corridors and rooms or those leading into spaces subject to occupancy, except elevator doors, shall be swing-type. Openings to showers, baths, patient toilets, and other small wet areas not subject to fire hazard are exempt from this requirement.

(f) Doors, except those to spaces such as small closets not subject to occupancy, shall not swing into corridors in a manner that obstructs traffic flow or reduces the required corridor width.

(g) Windows shall be designed to prevent accidental falls when open, or shall be provided with security screens where deemed necessary by the functional program.

(h) Windows and outer doors that may be frequently left open shall be provided with insect screens.

(i) Patient rooms intended for occupancy shall have windows that operate without the use of tools and shall have sills not more than three feet above the floor.

(j) Doors, sidelights, borrowed light, and windows glazed to within 18 inches of the floor shall be constructed of safety glass, wired glass, or plastic glazing material that resists breaking or creates no dangerous cutting edges when broken. Similar materials shall be used in wall openings of playrooms and exercise rooms. Safety glass or plastic glazing material shall be used for shower doors and bath enclosures.

(k) Linen and refuse chutes shall comply with the New Jersey Uniform Construction Code, N.J.A.C. 5:23.

(*l*) Thresholds and expansion joint covers shall be flush with the floor surface, to facilitate use of wheelchairs and carts.

(m) Grab bars shall be provided at all patient toilets, bathtubs, showers, and sitz baths. The bars shall have one and one-half inches clearance to walls and shall be sufficiently anchored to sustain a concentrated load of 250 pounds. Special consideration shall be given to shower curtain rods which may be momentarily used for support.

(n) Recessed soap dishes shall be provided in showers and bathrooms.

(*o*) Handrails shall be provided on both sides of corridors used by patients. A clear distance of one and one-half inches shall be provided between the handrail and wall, and the top of the rail shall be 32 inches above the floor.

(p) Ends of handrails and grab bars shall be constructed to prevent snagging the clothes of patients.

(q) The location and arrangement of handwashing facilities shall permit proper use and operation. Particular care shall be given to clearance required for blade-type operating handles. Lavatories intended for use by handicapped patients shall be installed to permit wheelchairs to fit under them.

(r) Mirrors shall be arranged for use by wheelchair patients as well as by patients in a standing position.

(s) Provisions for hand drying shall be included at all handwashing facilities.

(t) Lavatories and handwashing facilities shall be securely anchored to withstand an applied vertical load of not less than 250 pounds on the front of the fixture.

(u) Radiation protection requirements of x-ray and gamma ray installations shall conform to applicable State and local laws. Provisions shall be made for testing the completed installation before use. All defects shall be corrected before use of equipment.

(v) The minimum ceiling height shall be seven feet 10 inches, with the following exceptions:

1. Boiler rooms shall have a ceiling clearance not less than two feet six inches above the main boiler header and connecting piping.

2. Ceilings of radiographic and other rooms containing ceiling-mounted equipment, including those with ceiling-mounted surgical light fixtures, shall have sufficient height to accommodate the equipment and/or fixtures.

3. Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms shall not be less than seven feet eight inches.

4. Suspended tracks, rails, and pipes located in the path of normal traffic shall not be less than six feet eight inches above the floor.

(w) Recreation rooms, exercise rooms, and similar spaces where impact noises may be generated shall not be located directly over patient bed areas unless special provisions are made to minimize such noise.

(x) Rooms containing heat-producing equipment (such as boiler or heater rooms and laundries) shall be insulated and ventilated to prevent any floor surface above and below from exceeding a temperature 10 degrees Fahrenheit (six degrees Celsius) above the ambient room temperature.

(y) Noise reduction criteria shown in Table 1 of the Guidelines for Construction and Equipment of Hospital and Medical Facilities, 1987 edition, as published by the American Institute of Architects Press, incorporated herein by reference, shall apply to partition, floor, and ceiling construction in patient areas.

8:43H–24.27 Finishes

(a) Cubicle curtains and draperies shall be noncombustible or rendered flame retardant.

(b) Floor materials shall be readily cleanable and wear resistant for the location. Floors in food preparation or assembly areas shall be water resistant. Joints in tile and similar material in such areas shall also be resistant to food acids. In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions. Floors subject to traffic while wet, such as shower and bath areas, kitchens, and similar work areas, shall have a non-slip surface.

(c) Wall bases in kitchens, soiled workrooms and other areas that are frequently subject to wet cleaning methods shall be monolithic and coved with the floors, tightly sealed within the wall, and constructed without voids that can harbor insects.

(d) Wall finishes shall be washable and, in the proximity of plumbing fixtures, shall be smooth and moisture-resistant. Finish, trim, and floor and wall construction in dietary and food preparation areas shall be free from spaces that can harbor pests.

(e) Floor and wall areas penetrated by pipes, ducts, and conduits shall be tightly sealed to minimize entry of pests. Joints of structural elements shall be similarly sealed.

(f) Ceilings throughout shall be readily cleanable. All overhead piping and ductwork in the dietary and food preparation area shall be concealed behind a finished ceiling. Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and similar spaces, unless required for fire-resistive purposes.

(g) Acoustical ceilings shall be provided for corridors in patient areas, nurses stations, dayrooms, recreational rooms, dining areas, and waiting areas.

8:43H–24.28 Optional services

(a) If a urology service is provided it shall include:

1. One hundred square feet per examination table in the urology unit, with cubicle curtains for each patient for privacy, if more than one table is provided;
2. Storage space for equipment;
3. A handwashing sink;
4. A soiled utility room with lavatory;
5. Office space;
6. A charting area; and
7. A storage area for supplies.

(b) If personal care services for inpatients are provided, a separate room with appropriate fixtures and utilities shall be provided for patient grooming. This function can be performed in patient's bedroom, if part of his or her rehabilitation program.