Section was "Hearings".

SUBCHAPTER 3. GENERAL REQUIREMENTS

8:42–3.1 Compliance with rules and laws

(a) The facility shall provide preventive, rehabilitative, and therapeutic services to patients. This shall include, but not be limited to, nursing, homemaker-home health aide, and physical therapy services. Nursing services shall be available 24 hours a day, seven days a week.

(b) The facility shall routinely provide nursing services through its own staff. Nursing services provided under contract shall be rendered only if the following conditions pertain:

1. During temporary periods when all available full and part-time employees have achieved maximum caseloads, or;

2. To provide specialized care which is not available through existing staff;

3. Contracted nursing personnel are oriented to the policies and procedures of the facility and receive supervision from supervisory staff employed by the facility; and

4. Provisions are made for continuity of patient care by the same contracted nursing personnel whenever possible.

(c) Other services such as physical therapy, occupational therapy, speech-language pathology, dietary counseling, homemaker-home health aide and social work services shall be available directly or through written agreement.

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

(e) The facility shall adhere to all applicable provisions of N.J.S.A. 26:2H–1 et seq., and amendments thereto.

Amended by R.2000 d.340, effective August 21, 2000.
See: N.J.R. 627(a), 32 N.J.R. 3064(a).
In (b), deleted "in order to provide specialized care which is unavailable through existing staff" at the end of 1, inserted a new 2, and recodified former 2 and 3 as 3 and 4; and in (c), deleted "audiology" following "pathology,", and inserted "homemaker-home health aide" following "counseling,".

8:42–3.2 Ownership

(a) The ownership of the facility 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 Certificate of Need and Acute Care Licensure Program of the Department in writing at least 30 days prior to the change and in conformance with the requirements for Certificate of Need applications.

(b) No health care 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.

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).
In (a), substituted "Certificate of Need and Acute Care Licensure" for "Licensing, Certification and Standards".

8:42–3.3 Submission of documents

The facility shall, upon request, submit any documents which are required by these rules to the Director of the Certificate of Need and Acute Care Licensure Program of the Department.

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).
Substituted "Certificate of Need and Acute Care Licensure" for "Licensing, Certification and Standards".

8:42–3.4 Personnel

(a) The facility shall ensure that the duties and responsibilities of all personnel are described in job descriptions and in the policy and procedure manual for each service.

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

(c) All personnel, both directly employed and under contract to provide direct care to patients, shall at all times wear or produce upon request employee identification.

(d) The facility shall have policies and procedures for the maintenance of confidential personnel records for each employee, including at least his or her name, previous employment, educational background, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials and references, health evaluation records, job description, and evaluations of job performance.

(e) All new personnel, both directly employed and under contract to provide direct patient care, shall receive an initial health evaluation which includes at least a documented history.

(f) Employee health records shall be maintained for each employee. Employee health records shall be confidential and kept separate from personnel records.

(g) The employee health record shall include documentation of all medical screening tests performed and the results.

(h) All personnel, both directly employed and under contract to provide direct care to patients, shall receive a Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions are personnel with documented negative Mantoux skin test results

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(zero to nine millimeters of induration) within the last year, personnel with documented positive Mantoux skin test results (10 or more millimeters of induration), personnel who received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests shall be acted upon as follows:

1. If the Mantoux tuberculin skin test result is between zero and nine millimeters of induration, the test shall be repeated one to three weeks later.

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

(i) The Mantoux tuberculin skin test shall be administered to all agency personnel, both directly employed and under contract at the time of employment. To the extent, if any, that currently employed personnel have not been tested, they shall be tested immediately. The tuberculin skin test shall be repeated on an annual basis for all persons who provide direct patient care and every two years for all other employees.

(j) All personnel, both directly employed and under contract to provide direct care to patients, shall be given a rubella screening test using the rubella hemagglutination inhibition test or other rubella screening test. The only exceptions are personnel who can document seropositivity from a previous rubella screening test or who can document inoculation with rubella vaccine, or when medically contraindicated.

(k) The facility shall inform each person in writing of the results of his or her rubella screening test.

(*l*) The facility shall maintain a list identifying the name of each person who is seronegative and unvaccinated.

(m) All personnel, both directly employed and under contract to provide direct care to patients, who were born in 1957 or later shall be given a (measles) rubeola screening test using the hemagglutination inhibition test or other rubeola screening test. The only exceptions are personnel who can document receipt of live measles vaccine on or after their first birthday, physician-diagnosed measles, or serologic evidence of immunity.

(n) The facility shall ensure that all personnel, both directly employed and under contract to provide direct care to patients, who cannot provide serologic evidence of immunity are offered rubella and rubeola vaccination.

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).
In (i) deleted "by December 1, 1992" following "administered", and deleted "and thereafter to all new personnel" following "contract" in the first sentence, and inserted a new second sentence; deleted former (j); and recodified former (k) through (*o*) as (j) through (n).

8:42–3.5 Policy and procedure manual

(a) A policy and procedure manual(s) for the organization and operation of the facility shall be established, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility at all times. The manual(s) shall include at least the following:

1. A written narrative of the program describing its philosophy and objectives, and the services provided by the facility;

2. An organizational chart delineating the lines of authority, responsibility, and accountability, so as to ensure continuity of care to patients;

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

4. Definition and specification of full-time employment;

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

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

ii. The designation of a staff member(s) to be responsible for coordinating the reporting of child abuse and/or neglect in compliance with N.J.S.A. 9:6–1 et seq., recording notification of the Division of Youth and Family Services on the medical/health record, and serving as a liaison between the facility and the Division of Youth and Family Services; and

iii. The provision at least annually of education and/or training programs for all staff and subcontracted personnel who provide direct patient care regarding the identification and reporting of child abuse and/or neglect; sexual abuse; domestic violence; and abuse of the elderly or disabled adult.

NOTE: Copies of the law may be obtained from the local district office of the Division of Youth and Family Services (DYFS) or from the Office of Community Education, Division of Youth and Family Services, New Jersey State Department of Human Services, PO Box 717, Trenton, NJ 08625.

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

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).
In the note that follows (a)5, substituted "Community Education" for "Program Support" following " Office of".

1. Performing a psychosocial assessment of the patient; preparing the social work plan of care based on the assessment; and providing social work services to the patient as specified in the social work plan of care. Each of these activities shall be documented in the patient's medical/health record;

2. Communicating and documenting the communication with other disciplines and services to provide continuity and coordination of patient care;

3. Contacting community social service and other resources as needed for information, referrals, and services;

4. Providing social work counseling to the patient and his or her family; and

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

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).
Rewrote (a).

8:42–9.3 Social work entries in the medical/health record

(a) The social worker shall document in the patient's medical/health record:

1. The social work plan of care, which may be the social work portion of the patient treatment plan. The plan of care shall be reviewed and revised by the social worker; and

2. Clinical notes and progress notes.

SUBCHAPTER 10. DIETARY COUNSELING SERVICES

8:42–10.1 Services

Dietary counseling services may be provided directly or through written agreement to patients who need these services.

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).
Deleted (a) designation; and deleted former (b).

8:42–10.2 Responsibilities of dietitian

(a) For those patients requiring dietary counseling services, each dietitian shall be responsible for, but not limited to, the following:

1. Assessing the dietary needs of the patient, preparing the dietary plan of care based on the assessment and providing dietary counseling services to the patient as specified in the dietary plan of care. These activities shall be documented in the patient's medical/health record;

2. Communicating and documenting the communication with other disciplines and services to provide continuity and coordination of patient care; and

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

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).
Rewrote (a).

8:42–10.3 Dietary entries in the medical/health record

(a) The dietitian shall document in the patient's medical/health record:

1. The dietary plan of care, which may be the dietary counseling portion of the patient's plan of care. The plan of care shall be reviewed and revised by the dietitian; and

2. Clinical notes and progress notes.

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).
In (a), deleted references to dietary consultants throughout.

SUBCHAPTER 11. MEDICAL/HEALTH RECORDS

8:42–11.1 Medical/health records organization

(a) The facility shall develop written objectives, policies and procedures, an organizational plan, and a quality assurance program for medical/health records services. The quality assurance program shall include monitoring medical/health records for accuracy, completeness, legibility, and accessibility.

(b) At least 14 days before a facility plans to cease operations, it shall notify the New Jersey Department of Health and Senior Services in writing of the location and method for retrieval of medical/health records.

(c) There shall be a system for identifying medical/health records to facilitate their retrieval by patient identifier.

(d) Medical/health records shall be organized with a uniform format for all records.

(e) The patient's medical/health record shall be available to the health care practitioners involved in the patient's care.

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).

8:42–11.2 Medical/health records policies and procedures

(a) The facility shall have written policies and procedures for medical/health records that are reviewed annually, revised as needed and implemented. They shall include at least:

1. Clinical documentation shall be included in the medical/health record within 14 days;

2. Procedures for record completion, including review for accuracy and completion, which shall occur within 45 days;

3. Procedures for the protection of medical record information against loss, tampering, alteration, destruction, or unauthorized removal or use;

4. Conditions, procedures, and fees for releasing medical information; and

5. Release and/or provision of copies of the patient's medical/health record to the patient and/or the patient's authorized representative, including, but not limited to, the following:

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

ii. Availability of the patient's medical/health record to the patient's authorized representative if it is medically contraindicated (as documented by a physician in the patient's medical/health record) for the patient to have access to or obtain copies of the record; and

iii. Procedures to ensure that a copy of the patient's medical/health record is provided within 30 calendar days of a written request.

(b) All entries in the patient's medical/health record shall be typewritten or, written legibly in ink, and shall include date, signature and title, or computer generated with authentication if an electronic system is used.

(c) A medical/health record shall be initiated for each patient upon admission and shall include at least the following:

1. Patient identification data, including name, date of admission, address, date of birth, sex, race and religion (optional), next of kin, and person to notify in an emergency;

2. Name, address, and telephone number of the patient's physician, an alternate physician, and other primary health care providers if any;

3. A plan of treatment as defined at N.J.A.C. 8:42–1.2. This plan shall be:

i. Initiated and implemented when the patient is admitted;

ii. Coordinated and maintained by the nursing service or the physical therapy service, if physical therapy is the sole service;

iii. Inclusive of, but not limited to, the patient's diagnosis, patient goals, means of achieving goals, and care and treatment to be provided;

iv. Current and available to all personnel providing patient care; and

v. Included in the patient's medical/health record.

4. A plan of care as defined at N.J.A.C. 8:42–1.2, including an assessment and plan by each discipline involved in the patient's care;

5. All physician orders;

6. All telephone orders, which must be countersigned by a physician within 30 days;

7. Clinical notes;

8. Progress notes;

9. A record of medications if 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.

10. A record of medications shall include action, side effects and contraindications of medications where clinically indicated;

11. Documentation of allergies in the medical/health record;

12. An immunization record, in accordance with the facility's policies and procedures;

13. Written informed consents if indicated;

14. A copy of the patient's advance directive, if available, or documentation of the existence or nonexistence of an advance directive; and documentation of the agency's inquiry to the patient, family, or health care representative regarding this;

15. Documentation of written instructions given to the patient and/or the patient's family;

16. A record of any treatment, medication, or service in the service plan that is not provided and the reason, including patient refusal; and

17. A comprehensive discharge summary with narrative information from each service within 30 days of discharge unless the patient is readmitted during that 30 day period.

(d) If the patient is transferred to another non acute health care facility, the agency shall maintain a transfer record reflecting the patient's immediate needs and send a copy of this record to the receiving facility at the time of transfer. The transfer record shall contain at least the following information:

1. Diagnosis, including history of any serious conditions unrelated to the proposed treatment which might require special attention to keep the patient safe;

2. Physician orders in effect at the time of transfer and the last time each medication was administered;

3. The patient's plan of care;

4. Hazardous behavioral problems;

5. Drug and other allergies;

6. Reason for transfer; and

7. A notice of the existence of an advance directive and/or Do Not Resuscitate (DNR) order.

(e) All consent forms for treatment shall be printed in an understandable format and the text written in clear, legible, nontechnical language. If a family member or other patient representative signs the form, the reason for the patient's not signing it and the signer's relationship to the patient shall be indicated on the form.

(f) Medical records shall be completed within 45 days of discharge.

(g) The agency shall develop policies and procedures for the removal of the medical/health record, which shall occur only under the following conditions:

1. No medical/health record or parts thereof shall be removed from the agency except for purposes of providing clinical patient care and treatment;

i. Any such record or part thereof which is removed from the agency shall be returned to the agency during the next business day;

2. If there is a court order or subpoena for its release; or

3. To safeguard the record in case of a physical plant emergency or natural disaster; and

4. There shall be a system to protect the security and confidentiality of all components of the medical/health record at all times.

(h) Medical records shall be retained and preserved in accordance with N.J.S.A. 26:8–5 et seq.

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).
Rewrote the section.

SUBCHAPTER 12. INFECTION PREVENTION AND CONTROL

8:42–12.1 Infection prevention and control program

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

(b) The administrator shall designate a person who shall have education, training, completed course work, or experience in infection control or epidemiology, and who shall be responsible for the direction, provision, and quality of infection prevention and control services. The designated person shall be responsible for, but not limited to, developing and maintaining written objectives, a policy and procedure manual, a system for data collection, and a quality assurance program for the infection prevention and control service.

8:42–12.2 Infection control policies and procedures

(a) The facility shall have a multidisciplinary committee which establishes and implements an infection prevention and control program.

(b) The designated committee shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control, including, but not limited to, policies and procedures regarding the following:

1. Infection control and isolation, including Universal Precautions, in accordance with the Centers for Disease Control and Occupational Safety and Health Administration publication, "Enforcement Procedures for Occupational Exposure to Hepatitis B Virus (HVB) and Human Immunodeficiency Virus (HIV)," OSHA Instruction CPL 2–2.44A, August 15, 1988 or revised or later editions, if in effect incorporated herein by reference;

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. Aseptic technique, employee health, and staff training, the prevention of infection, and general improvement of patient care as it relates to infection control and prevention;

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. Sterilization, disinfection, and cleaning practices and techniques including, but not limited to, the following:

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

ii. Selection, storage, use, and disposition of single use and nondisposable patient care items;

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

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

7. Collection, handling, storage, decontamination, disinfection, sterilization, and disposal of regulated medical waste and all other solid or liquid waste.

NOTE: Centers for Disease Control publications can be obtained from:

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161
or
Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).
In (b), deleted former 6 and recodified former 7 and 8 as 6 and 7.

8:42–12.3 Infection control measures

(a) The facility shall follow all Category I recommendations in the current editions of the following Centers for Disease Control publications, and any amendments or supplements thereto, incorporated herein by reference:

1. Guideline for Prevention of Catheter-Associated Urinary Tract Infections;

2. Guideline for Prevention of Intravascular Infections;

3. Guideline for Prevention of Surgical Wound Infections; and

4. Guideline for Handwashing and Hospital Environmental Control.

8:42–12.4 Use and sterilization of patient care items

(a) The facility shall develop protocols for decontamination and sterile activities, including receiving, decontamination, storage, cleaning, packaging, labeling, disinfection, sterilization, transporting, and distribution of reusable items. These protocols shall ensure that:

1. Single use patient care items shall not be reused. Other patient care items which are reused shall be reprocessed and reused in accordance with manufacturers' recommendations;

2. Sterilized materials shall be marked with an expiration date and shall not be used subsequent to the expiration date;

3. Sterilized materials shall be packaged and labeled so as to maintain sterility and so as to permit identification of expiration dates; and

4. Expiration dates shall be assigned to sterilized materials in accordance with the following:

i. Double-wrapped muslin/paper wrappers shall be marked with an expiration date not to exceed one month following sterilization;

ii. Heat-sealed paper/plastic wrappers shall be marked with an expiration date not to exceed one year following sterilization; and

iii. Self-sealed packaging shall be marked with an expiration date not to exceed the manufacturer's recommendation.

8:42–12.5 Care and use of sterilizers

(a) Sterilizers shall be kept clean.

(b) Sterilizer drains shall be flushed at least weekly, unless otherwise specified by the manufacturer, and a record shall be maintained.

(c) At the completion of each sterilization load, the time, temperature, and pressure readings shall be checked and recorded.

(d) A record of each sterilization load, including the date, the load number, the contents of the load, and the expiration dates of the contents, shall be maintained for at least one year.

8:42–12.6 Regulated medical waste

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

(b) The facility shall comply with the provisions of the Medical Waste Tracking Act of 1988, and N.J.S.A. 13:1E–48.1 et seq., the Comprehensive Regulated Medical Waste Management Act, and all rules and regulations promulgated pursuant to the aforementioned Acts.

8:42–12.7 Communicable disease alert

The facility shall develop protocols for identifying and handling high-risk bodies, in accordance with the Centers for Disease Control guidelines and in compliance with N.J.S.A. 26:6–8. In accordance with the provisions of P.L. 1988, c.125 (Assembly bill 1457), the facility shall complete the New Jersey State Department of Health and Senior Services form HFE–4, "Communicable Diseases Alert," in applicable cases.

Amended by R.2000 d.340, effective August 21, 2000.
See: 32 N.J.R. 627(a), 32 N.J.R. 3064(a).

8:42–12.8 Orientation and in-service education

(a) Orientation for all new employees and staff under contract to provide direct patient care shall include infection control practices for the employee's specific discipline and the rationale for the practices.