# MANUAL OF STANDARDS FOR LICENSURE OF NON-RESIDENTIAL MEDICAL DAY CARE FACILITIES

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NEW JERSEY STATE DEPARTMENT OF HEALTH
TRENTON, NEW JERSEY

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## 1.0 Definitions

1.1 Activities of Daily Living (ADL) shall mean the functions or tasks for self-care which are performed by human beings either independently or with supervision or assistance. Activities of Daily Living shall include, at least, mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, and toileting.

1.2 Administrator shall mean a person with a baccalaureate degree and two years of executive or supervisory experience in a health care facility, or the equivalent in years of experience and/or training in a health care facility, or a licensed nursing home administrator who is licensed by the New Jersey State Department of Health pursuant to N.J.S.A. 26:2H-27 and 26:2H-28 (Chapter 356, P.L. 1968).

1.3 Ancillary Personnel shall mean unlicensed employees employed, such as technicians and aides, to assist licensed nursing personnel. Ancillary personnel are trained on the job in accordance with the staff education and staff orientation plans.

1.4 Assistive Device shall mean a leg brace, splint, cane, crutch(es), special shoe(s), back brace, walker, wheelchair, or prosthesis.

1.5 Available shall mean ready for immediate use (pertaining to equipment); capable of being reached (pertaining to personnel).

1.6 Business Hours shall mean a time period established by the facility, as defined in its policy manual.

1.7 Bylaws shall mean a set of rules adopted by the facility for governing its operation. (A charter, articles of incorporation, and/or a statement of policies and objectives are acceptable equivalents.)

1.8 Care Plan (Nursing, Dietary, Rehabilitation, Social Service, Patient Activities) shall mean a written plan documenting an assessment of the individual patient's needs, short- and long-term goals, and care and treatment to be provided. Prior to or upon admission of the

patient, a staff member from each service the patient is to receive shall initiate a care plan which shall be implemented at the time of the patient's admission. The care plan of each service is part of the total patient care plan and may be documented therein rather than as a separate document.

1.9 Cleaning shall mean 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.

1.10 Clinical Note shall mean a dated, written, and signed notation by each member of the health care team who renders a service to the patient, including a description of signs and symptoms, treatment and/or drugs given, the patient's reaction, and any changes in physical or emotional condition. Clinical notes are written into the patient's medical record the day service is rendered.

1.11 Commissioner shall mean the New Jersey State Commissioner of Health.

1.12 Communicable Disease shall mean an illness due to a specific infectious agent or its toxic products, and occurring through transmission of that agent or its products from a reservoir to a susceptible host.

1.13 Conspicuously Posted shall mean placed at a location accessible to and seen by patients, staff, and the public.

1.14 Contamination shall mean the presence of an infectious agent in the air, on a body surface, or on/in clothes, bedding, instruments or dressings, or other inanimate articles or substances, including water, beverages, and food.

1.15 Controlled Dangerous Drugs shall mean medications subject to the Controlled Dangerous Substances Act of 1970, the Controlled Dangerous Substances Act of 1971, and the New Jersey Administrative Code, Title 8, Chapter 65.

1.16 Current shall mean up-to-date, extending to the present time.

1.17 Daily Census (patient equivalents) shall mean the number of patients or patient equivalents who, during any one calendar day, receive services at the facility for at least five hours, excluding transportation time. Two or more patients may equal one full-time equivalent patient. This count is not dependent upon nor does it include the number or type of services a patient receives nor an actual individual, unduplicated census count.

1.18 Dentist shall mean a person who is licensed by the New Jersey State Board of Dentistry, pursuant to N.J.S.A. 45:6 et seq.

1.19 Department shall mean the New Jersey State Department of Health.

1.20 Dietitian or Dietary Consultant shall mean a person who:

1.20.1 Has a bachelor's degree from a college or university accredited by the American Dietetic Association, and has completed a dietetic internship or dietetic traineeship approved by the American Dietetic Association, or has a master's degree plus six months of full-time, or full-time equivalent, food service experience in a health care facility; or

1.20.2 Has a bachelor's degree from a college or university accredited by the American Dietetic Association with a major in foods or nutrition or the equivalent course work for a major in the subject area, and one year of full-time, or full-time equivalent, experience in nutrition; and

1.20.3 Participates annually in continuing dietary education.

1.21 Director of Nursing Services shall mean a registered professional nurse licensed in the State of New Jersey who:

1.21.1 Has at least two years of full-time, or full-time equivalent, experience in nursing supervision and/or nursing administration in a health care facility; and

1.21.2 Has education and/or experience in such areas as rehabilitative or geriatric nursing; and

1.21.3 Participates annually in continuing nursing education.

1.22 Discharge Plan (Medical, Nursing, Dietary, Rehabilitation, Social Service, Patient Activities) shall mean a written plan initiated at the time of the patient's admission and completed within 14 days by each service that the patient receives. The plan shall include the projected level(s) of care needed, the projected timetable for moving the patient to the next level of care, treatment and teaching needed prior to discharge, resources available for post-discharge care, and mechanisms for transfer to other levels of care.

1.23 Discharge Summary (Medical, Nursing, Dietary, Rehabilitation, Social Service, Patient Activities) shall mean a written summary prepared at the time of the patient's discharge by each service that the patient receives, and which includes treatment provided, results, reasons for discharge, preparation of the patient for discharge, and recommendations for the patient's maintenance regimen and continuity of care.

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

1.24.1 Concurrent disinfection shall mean the application of measures of disinfection as soon as possible after the discharge of infectious material from the body of an infected person, or after the soiling of articles with such infectious discharges, all personal contact with such discharges or articles being minimized prior to such disinfection.

1.24.2 Terminal disinfection shall mean the application of measures of disinfection after the patient has died, or has been removed, or has ceased to be a source of infection, or after the facility's isolation practices have been discontinued. Terminal disinfection is rarely practiced; terminal cleaning (see 1.9), along with airing and sunning of rooms, furniture, and bedding, generally suffices. Terminal disinfection is necessary only for diseases spread by indirect contact.

1.25 Documented shall mean a signed and dated notation or statement.

1.26 Drug Administration shall mean a procedure in which a prescribed drug or biological is given to a patient by an authorized person in accordance with all laws and regulations governing such procedures. The complete procedure of administration includes removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the patient, seeing that the patient takes it, and recording the required information including the method of administration.

1.27 Drug Dispensing shall mean a procedure entailing the interpretation of an order from the original or direct copy of the physician's order for a drug or biological and, pursuant to that order, the proper selection, measurement, labeling, packaging, and issuance of the drug or biological to a patient or a service unit of the facility, in conformance with the rules and regulations of the New Jersey State Board of Pharmacy.

1.28 Epidemic shall mean the occurrence or outbreak in a facility of one or more cases of an illness which are in excess of normal expectancy for that illness and which are derived from a common or propagated source.

1.29 Food Service Supervisor (Dietetic Service Supervisor) shall mean a person who:

1.29.1 Is a dietitian; or

1.29.2 Is a graduate of a dietetic technician or dietetic assistant training program approved by the American Dietetic Association; or

1.29.3 Is a graduate of a course, approved by the Department of Education, providing 90 or more hours of classroom instruction in food service supervision, and has one year of full-time, or full-time equivalent, experience as food service supervisor in a health care facility, with consultation from a dietitian; or

1.29.4 Has training and experience in food service supervision and management in a military service equivalent to the programs listed in 1.29.2 or 1.29.3.

1.30 Full-Time shall mean a time period of not less than 35 hours, established as a full working week by the facility, as defined in its policy manual.

1.31 Governing Authority shall mean the organization, person, or persons designated to assume full legal responsibility for the determination of policy, management, operation, and financial viability of the facility.

1.32 Guardian shall mean a person, appointed by a court of competent jurisdiction, who shall have the right to manage the financial affairs and protect the rights of any patient of the facility who has been declared a mental incompetent. In no case shall the guardian of a patient of the facility be affiliated with the facility, its operations, or its personnel, unless ordered by the court.

1.33 Health Care Facility shall mean a facility so defined in Chapters 136 and 138, P.L. 1971, Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq.

1.34 Home Health Agency shall mean a public or private agency, organization, or a subdivision of such an agency or organization, as defined in N.J.A.C. 8:42.1 et seq.

1.35 Job Description shall mean a written list developed for each position in the facility, containing the qualifications, duties and responsibilities, and accountability required of the person in that position.

1.36 Licensed Nursing Home Administrator shall mean a person who is licensed by the New Jersey State Department of Health, pursuant to N.J.S.A. 26:2H-27 and 26:2H-28 (Chapter 356, P.L. 1968).

1.37 Licensed Nursing Personnel (Licensed Nurses) shall mean registered professional nurses or practical (vocational) nurses licensed in the State of New Jersey.

1.38 Licensed Practical Nurse shall mean a person who is licensed by the New Jersey State Board of Nursing, pursuant to N.J.S.A. 45:11-27 et seq.

1.39 Medical Care Plan shall mean a written plan, completed prior to or upon the patient's admission and implemented at the time of the patient's admission, which includes the patient's medical history, diagnosis, disabilities or limitations, short- and long-term goals, assessment of physical capabilities, mental capacity, and rehabilitation potential, orders for medication, diet, and rehabilitation and patient activities services, special needs for the patient's health or safety, permitted level of physical activity, frequency of attendance at the medical day care facility, and the frequency with which the patient shall be seen by the physician.

1.40 Medical Day Care Facility shall mean a facility or a distinct part of a facility which is licensed by the New Jersey State Department of Health to provide health or health-related services under medical supervision for at least seven consecutive hours daily, including transportation time, a minimum of five days a week to two or more patients who are not related to the governing authority or its members by marriage, blood, or adoption. The facility shall provide at least nursing, dietary, social work, patient activities, rehabilitation, and transportation services directly or through written agreement. All services shall be available to patients on each day that the facility is in operation.

1.41 Medical Director shall mean a physician, as defined in 1.58.

1.42 Medical Record Practitioner shall mean a person who:

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

1.42.2 Is a graduate of a school of medical record science accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the American Medical Record Association.

1.43 Monitor shall mean to observe, watch, or check.

1.44 Multidisciplinary Team shall mean a group comprised of at least the following: a physician, who may be either the patient's attending physician or the medical director of the facility, a nurse, a social worker, a dietitian, a member of the rehabilitation service, and a member of the patient activities service. The team shall assess the patient, provide direct patient services, and make recommendations regarding admission, treatment, services provided, and discharge of the patient.

1.45 Nosocomial Infection shall mean an infection acquired by a patient while in the facility.

1.46 Nursing Care shall mean care given to a patient, as defined by the State of New Jersey Nursing Practice Act.

1.47 Occupational Therapist shall mean a person who:

1.47.1 Is a graduate of an occupational therapy curriculum accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the American Occupational Therapy Association; or

1.47.2 Is eligible for certification by the American Occupational Therapy Association as an occupational therapist, registered.

1.48 Occupational Therapy Assistant shall mean a person who has completed a training program approved by the American Occupational Therapy Association for occupational therapy assistants, or who is eligible for certification by the American Occupational Therapy Association.

1.49 Optometrist shall mean a person who is licensed by the New Jersey State Board of Optometrists, pursuant to N.J.S.A. 45:1-12 et seq.

1.50 Patient (Medical Day Care) shall mean a person who is 16 years of age or over, and who:

1.50.1 Does not require 24-hour inpatient or residential health care;

1.50.2 Is mobile under his/her own power, without human assistance or supervision, with or without assistive devices (see 1.4), and is able to leave the building by him/herself; and

1.50.3 Is certified by a physician to be free from communicable diseases and to be in need of the services provided by the medical day care facility, as documented in the patient's medical record.

1.51 Patient Activities Consultant shall mean a person who:

1.51.1 Is a therapeutic recreation specialist, as defined by the National Therapeutic Recreation Society; or

1.51.2 Is an occupational therapist; or

1.51.3 Is a recreation administrator certified by the New Jersey Board of Recreation Examiners and who has at least two years of full-time, or full-time equivalent, experience in a patient activities program in a health care facility.

1.52 Patient Activities Coordinator shall mean a person who:

1.52.1 Has a bachelor's degree from a college accredited by a state department of education with a major in recreation, occupational therapy, or a field related to recreation, such as art, music, physical education, group work, or sociology; or

1.52.2 Has an associate degree in recreation and two years of full-time, or full-time equivalent, experience in recreation for the aged, handicapped, or retarded; or

1.52.3 Has a high school diploma or equivalency certificate, two years of full-time, or full-time equivalent, experience in a social or recreational program within the last five years, one year of which was full-time in a patient activities program in a health care facility, and has completed at least 36 hours of classroom training, approved by the Department, in activities programming; or

1.52.4 Is certified by the New Jersey Board of Recreation Examiners as a recreation administrator or recreation supervisor, pursuant to Chapter 291, P.L. 1966; or

1.52.5 Is an occupational therapy assistant.

1.53 Patient Care Plan shall mean a written plan coordinated and maintained by the nursing service, with documentation of joint planning, the cooperation of all other services that the patient receives and the participation of the patient and/or the next of kin, sponsor and/or guardian, initiated prior to or upon the patient's admission, and included in the medical record at the time of discharge. It contains the physician's orders, diagnosis, goals of care to be provided, a care plan from each of the services that the patient receives, scheduled days of attendance, participation in recreational activities, transportation needs, diet, prognosis, prospective length-of-stay, and projected discharge. The patient care plan shall be kept current and available to all personnel providing patient care.

1.54 Pharmacist shall mean a person who is registered by the New Jersey State Board of Pharmacy, pursuant to N.J.S.A. 45:14 et seq., and who has experience and/or training in institutional pharmacy.

1.55 Pharmacist Consultation Sheet shall mean an individual patient record included in the medical record, containing information regarding the review of the patient's drug regimen by the staff pharmacist or consultant pharmacist, laboratory tests, dietary requirements, physician's and nurse's clinical notes, physician's orders, and progress notes, in order to monitor potential adverse drug reactions, allergies, drug interactions, contraindications, rationality, drug evaluation, and laboratory test modifications. The pharmacist shall review and sign the pharmacist consultation sheet, including the drug regimen, in accordance with a schedule justified and documented in the patient's medical record.

1.56 Physical Therapist shall mean a person who is registered by the New Jersey Board of Medical Examiners, pursuant to Chapter 169, P.L. 1963, and who:

1.56.1 Has graduated from a physical therapy curriculum approved by the American Physical Therapy Association; or

1.56.2 Prior to January 1966:

1.56.2.1 Was admitted to membership by the American Physical Therapy Association; or

1.56.2.2 Was admitted to registration by the American Registry of Physical Therapists; or

1.56.2.3 Graduated from a physical therapy curriculum in a four-year college or university approved by a state department of education, and is licensed or registered as a physical therapist; or

1.56.2.4 Had two years of full-time, or full-time equivalent, experience as a physical therapist and has achieved a satisfactory grade through the examination conducted by or under the sponsorship of the United States Public Health Service; or

1.56.2.5 Was licensed or registered prior to January 1, 1966 and, prior to January 1, 1970, had 15 years of full-time, or full-time equivalent, experience in the treatment of illness or injury through the practice of physical therapy, in which the therapist rendered services upon the order and under the direction of attending and referring physicians; or

1.56.3 If trained outside the United States:

1.56.3.1 Graduated after 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and

1.56.3.2 Is a member of a member organization of the World Confederation for Physical Therapy; and

1.56.3.3 Has acquired one year of full-time, or full-time equivalent, experience under the supervision of an active member of the American Physical Therapy Association; and

1.56.4 Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

1.57 Physical Therapy Assistant shall mean a person who is registered by the New Jersey Board of Medical Examiners, pursuant to Chapter 169, P.L. 1963.

1.58 Physician shall mean a person who is licensed or authorized by the Board of Medical Examiners to practice medicine in the State of New Jersey, pursuant to N.J.S.A. 45:9-1 et seq.

1.58.1 Attending physician(s) shall mean the physician(s) responsible for the medical care of a patient.

1.59 Podiatrist shall mean a person who is licensed by the Board of Medical Examiners to practice podiatry in the State of New Jersey, pursuant to N.J.S.A. 45:5-1 et seq.

1.60 Positive Tuberculin Reactor shall mean a person who has a positive intradermal tuberculin test, determined on the basis of either a Mantoux test with five tuberculin units of stabilized purified protein derivative, or a vesiculation following a multiple puncture tuberculin test.

1.61 Program Director of a Medical Day Care Facility shall mean a person who qualifies under the laws of New Jersey as a licensed nursing home administrator, registered professional nurse, public health nurse, physician, occupational therapist, physical therapist, speech-language pathologist, social worker, or patient activities consultant; and who has one year of full-time, or full-time equivalent, experience in a health care facility.

1.62 Progress Note shall mean a signed, dated notation by a member of the health care team (excluding ancillary personnel) summarizing information about medical or health care provided and the patient's response to it.

1.63 Public Health Nurse shall mean a person licensed as a registered professional nurse, who has completed a baccalaureate degree program approved by the National League for Nursing for public health nursing preparation or post-baccalaureate study which includes content approved by the National League for Nursing for public health nursing preparation.

1.64 Reality Orientation shall mean a system to orient the patient to his/her environment in relation to time, place, and person, so that the patient is given the opportunity to become aware of who and where he/she is, and of the time, day, month, and year.

1.65 Registered Professional Nurse shall mean a person who is licensed by the New Jersey State Board of Nursing, pursuant to N.J.S.A. 45:11-26 et seq.

1.66 Self-administration shall mean a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a patient to him/herself. The complete procedure of self-administration includes the patient's bringing the medication to the facility, removing an individual dose from a previously dispensed, labeled container (including a unit dose container), verifying it with the directions on the label, and taking orally, injecting, inserting, or topically or otherwise administering the medication.

1.67 Signature shall mean at least the first initial and full surname and title (for example, R.N., M.D., D.D.S.) of a person written with his/her own hand.

1.68 Single Unit Dose Packaging Drug Distribution System (hereinafter referred to as unit dose system) shall mean a system in which drugs are delivered by a pharmacy to patient areas in single unit packaging, individually wrapped and labeled with the name and strength of medication, lot number, and expiration date if available, and ready for administration to patients. The number of doses for each patient shall be sufficient for a maximum of 48 consecutive hours.

1.69 Social Work Designee shall mean a person with a bachelor's degree in social sciences or a high school graduate with four years of full-time, or full-time equivalent, social service experience in a health care facility. One year of experience may be substituted for each year of college.

1.70 Social Worker shall mean a person who has a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education and at least one year of full-time, or full-time equivalent, social work experience in a health care facility.

1.71 Speech-language Pathologist or Audiologist shall mean a person who:

1.71.1 Meets the requirements for education and experience for a Certificate of Clinical Competence in the appropriate area (speech-language pathology or audiology) granted by the American Speech and Hearing Association; or

1.71.2 Meets the educational requirements and is in the process of accumulating the required supervised experience for a Certificate of Clinical Competence in the appropriate area (such as speech-language pathology or audiology) granted by the American Speech and Hearing Association.

1.72 Staff Education Plan shall mean a written plan developed and revised at least annually and implemented throughout the year which describes a coordinated program for staff education for each service, including inservice programs and education, training in patient rights, staff development, on-the-job training, and continuing education, and the intervals and times at which these shall be given. Each employee shall receive education to develop skills and increase knowledge so as to improve patient care. Occasional attendance at programs or conventions or at lectures by invited speakers does not alone constitute an acceptable staff education plan.

1.73 Staff Orientation Plan shall mean a written plan for the orientation of each new employee to the duties and responsibilities of the service to which he/she has been assigned and to the personnel policies of the facility. The facility shall provide an orientation for each new employee which shall begin no later than the first day of employment.

1.74 Sterilization shall mean a process of destroying all microorganisms, including those bearing spores.

1.75 Stop Order shall mean a signed, dated, written statement by a physician mandating the cessation of a written order.

1.76 Supervision shall mean authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his/her sphere of competence, with initial direction and periodic onsite inspection of the actual act of accomplishing the function or activity.

1.76.1 Direct Supervision shall mean supervision on the premises within view of the supervisor.

1.77 Therapeutic Diet shall mean a diet prescribed by a physician, and may include modifications in nutrient content, caloric value, consistency, methods of food preparation, content of specific foods, or a combination of these modifications.

1.78 Transportation Services shall mean the conveying of patients between the facility and the patient's home, as well as to and from services provided indirectly by the facility. No patient's total daily transportation time shall exceed two hours.

1.79 Unit Record System shall mean a system of filing the medical record as one unit, in one location within the facility.

## 2.0 Licensure Procedure

### 2.1 Certificate of Need

2.1.1 According to Chapters 136 and 138, P.L. 1971, Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., 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.

2.1.2 Application forms for a Certificate of Need and instructions for completion may be obtained from:

Division of Health Planning and
Resources Development
Review and Comment Unit
New Jersey State Department of Health
P.O. Box 1540
Trenton, NJ 08625

### 2.2 Newly Constructed or Expanded Facilities

2.2.1 The application for license for a new facility shall include written approval of final construction of the physical plant by the Office of Health Care Facilities Construction and Monitoring, Division of Health Planning and Resources Development, Department of Health.

2.2.2 A temporary license may be issued to a newly constructed facility for the first six months of operation when the following conditions are met:

2.2.2.1 An office conference has taken place between the Licensing, Certification and Standards Program and a representative of the facility's governing authority, the administrator, and administrative personnel, consisting of a review of the conditions for licensure and operation;

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

2.2.2.3 Written approvals of the water supply and the sewage disposal system from local officials are on file for any water supply or

sewage disposal system not connected to an approved municipal system;

2.2.2.4 A final onsite inspection has been made by representatives of the Health Care Facilities Construction and Monitoring Program and the Health Facilities Inspection Program, New Jersey State Department of Health, P.O. Box 1540, Trenton, New Jersey 08625, who verify that the building has been constructed in accordance with the final architectural plans approved by the Department; and

2.2.2.5 Professional personnel are employed in compliance with staffing standards established by the Department.

2.2.3 No health care facility shall accept patients until the facility has the approval and/or license issued by the Department. The facility shall accept only that number of patients for which it is approved and/or licensed.

2.2.4 Any health care facility with a construction program, whether a Certificate of Need is required or not, must submit plans to the Department for review and approval prior to the initiation of any work.

2.3 Application for Licensure

2.3.1 Following acquisition of a Certificate of Need, any person, organization, or corporation desiring to operate a facility shall make application to the Commissioner of Health for a license on forms prescribed by the Department. Such forms may be obtained by submitting a request to:

Licensing, Certification and Standards
Division of Health Facilities Evaluation
New Jersey State Department of Health
P.O. Box 1540
Trenton, New Jersey 08625

2.3.2 The Department shall charge a non-refundable fee of $100 for the filing of an application for licensure or renewal of licensure of a facility operating solely as a medical day care center.

2.3.3 A non-refundable licensure or renewal of licensure filing fee of $50 shall be charged by the Department to any facility that is

currently licensed by the Department and is expanding its services to include medical day care services.

2.3.4 Any individual or individuals considering application for license to operate a facility shall make an appointment for a preliminary conference at the Department with the Licensing, Certification and Standards Program.

2.4 Surveys

2.4.1 When the written application for licensure is approved and the building is said to be ready for occupancy, a survey of the facility by representatives of the Health Facilities Inspection Program of the Department shall be conducted.

2.4.2 The findings of the survey with respect to adherence to the licensure standards shall be documented and a letter noting any deficiencies found forwarded to the facility.

2.4.3 Following receipt of the letter noting deficiencies, the facility shall notify the Health Facilities Inspection Program of the Department when the deficiences have been corrected.

2.4.4 A resurvey of the facility, to be conducted by the Health Facilities Inspection Program of the Department following correction of the deficiencies, will be scheduled prior to occupancy as needed.

2.4.5 If, on the basis of the Departmental survey, the facility meets the licensure standards, the facility will be issued a temporary license valid for six months.

2.4.6 Survey visits may be made to a facility at any time by authorized staff of the Health Facilities Inspection Program of the Department. Such visits may include, but not be limited to, the review of all facility and patient records and conferences with patients.

2.5 Full License

2.5.1 A full license shall be issued on expiration of the temporary license, if periodic surveys by the Health Facilities Inspection Program of the Department have determined that the health care facility is operated as required by

Chapters 136 and 138, P.L. 1971 and by the rules and regulations pursuant thereto.

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

2.5.3 The temporary license or the license shall be conspicuously posted in the facility.

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

2.5.5 The temporary license or the license, pending Departmental approval or unless sooner suspended or revoked, shall be renewed annually on the original licensure date, or within 30 days thereafter but dated as of the 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.

2.5.6 The temporary license or the license may not be renewed if local regulations or any other requirements are not met.

2.6 Surrender of License

2.6.1 The facility shall directly notify each patient concerned, the patient's physician, and any third party payors concerned at least 30 days prior to the voluntary surrender of a license, or as directed under an order of revocation, refusal to renew, or suspension of license. In such cases, the license shall be returned to the Department within seven working days.

2.7 Waiver

2.7.1 The Commissioner or his/her designee may, in accordance with the purposes and intent of Chapters 136 and 138, P.L. 1971 and the standards in this document, waiver sections of the regulations if, in his/her opinion, such waiver would not endanger the life, safety, or health of the patients, staff, or public.

2.7.2 A facility seeking a waiver of these standards shall apply in writing to:

Director of Licensing, Certification and Standards
Division of Health Facilities Evaluation
New Jersey State Department of Health
P.O. Box 1540
Trenton, NJ 08625

2.7.3 A written application for waiver shall include the following:

2.7.3.1 The nature of the waiver requested;

2.7.3.2 The specific standards for which waiver is requested;

2.7.3.3 Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon full compliance;

2.7.3.4 An alternative proposal which would ensure patient safety;

2.7.3.5 Documentation to support the application for waiver; and

2.7.3.6 If the standards to which waiver is sought contain additional or particular requirements regarding waiver, a discussion of such requirements.

2.7.4 The Department reserves the right to request additional information before processing an application for waiver.

2.8 Action against a License

2.8.1 Violations of the following standards shall result in action to impose a fine: 2.1, 2.2.3, and 2.2.4.

2.8.2 Violations of the Life Safety Code not corrected within a period of time approved by the Department shall result in action to revoke the license of the facility.

2.8.3 Violations of physical plant standards other than the Life Safety Code, not waivered or corrected within one year, shall result in action to reduce the license to provisional status.

2.8.3.1 Failure to correct violations of physical plant standards within the 90-day time period of the provisional license, or within an alternative time period approved by the Department, shall result in action to revoke the license of the facility.

2.8.4 If the Department determines that serious 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. The Commissioner or the Commissioner's designee shall notify the facility in writing of such determination.

2.8.5 The Commissioner may order the immediate removal of patients from a medical day care facility whenever he/she determines imminent danger to any person's health or safety.

## 3.0 General Requirements

3.1 The facility shall provide health or health-related services under medical supervision to patients who do not require 24-hour inpatient or residential health care.

3.1.1 The facility shall be in operation at least seven consecutive hours daily, a minimum of five days a week. Patients shall have available to them at least five hours of medical day care services, excluding transportation time, each day they are present in the facility. No patient's total daily transportation time shall exceed two hours.

3.1.2 All medical day care services shall be available on each day that the facility is in operation.

3.2 The facility shall comply with applicable federal, state, and local regulations and requirements, including but not limited to:

3.2.1 Building;

3.2.2 Zoning;

3.2.3 Fire;

3.2.4 Safety;

3.2.5 Health; and

3.2.6 Civil Rights.

3.3 The facility shall comply with all applicable provisions contained in Chapters 136 and 138, P.L. 1971, Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq. and amendments thereto.

3.4 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 made available to representatives of the Department. Any proposed change in ownership shall be reported to the Department in writing 30 days prior to the change.

3.5 No facility shall be owned and/or operated by a person convicted of a misdemeanor or a high misdemeanor relating adversely to his/her

capability of owning or operating that facility unless that person is considered rehabilitated, as stipulated in the Rehabilitated Convicted Offenders Act, N.J.S.A. 2A:168A-1 et seq.

3.6 The facility shall, upon request, submit in writing any plans, manuals, and other documents which, as mandated by the standards in this document, require the approval of the Department, to:

Licensing, Certification and Standards
Division of Health Facilities Evaluation
New Jersey State Department of Health
P.O. Box 1540
Trenton, NJ 08625

3.7 All records, reports, and documents required by the standards in this document shall be kept available in the facility at all times and shall be furnished to the Department upon request.

3.7.1 All records, reports, and documents required by the standards in this document shall be retained for a period of at least three years after the date of the annual licensure inspection. Thereafter they shall be retained as required by the applicable local, state, and federal laws.

3.7.2 All records, reports, documents, policies, and manuals specified in these standards shall be made available, upon request, to patients, staff, and the public. Patients' records shall be made available upon the written consent of the patient, unless medically contraindicated, after such deletions as are required by law are made. If any of the requested records, reports, documents, policies, and manuals contain information involving confidential corporate or business materials, such information may be deleted. However, if such information is deleted, the administrator shall inform the requesting party in writing of the reasons for the deletions. Copies of these documents shall be provided, upon request, at a reasonable charge and within 30 days of the request.

3.8 All personnel who require licensure or authorization shall be licensed or authorized under the appropriate laws or regulations of the State of New Jersey.

3.9 The facility shall be responsible for providing or arranging services for patients as required by the standards in this document.

3.10 A written policy and procedure manual approved by the Department shall be developed and implemented as a guide for organization and operation of the facility. It shall be reviewed annually, the review shall be documented, and any revisions shall be approved by the Department. The manual shall include at least:

3.10.1 A narrative of the program describing the services provided, staffing patterns, space requirements, delineation of the geographic areas to which service is provided, and other information relating to the agency's objectives;

3.10.2 An organizational chart delineating the lines of authority, responsibility, and accountability, organized and functioning so as to ensure an integrated continuum of services for the patient;

3.10.3 All policies and procedures for each of the services provided;

3.10.4 A description of referral mechanisms and linkages with consultants, inpatient facilities, ambulatory care facilities, and other community resources in order to provide continuity of patient care;

3.10.5 A description of the system for maintenance of patient records while the facility is in operation, and in the event that it ceases to operate;

3.10.6 A description of the process of evaluation, including patient care, staff performance, and facility of operation;

3.10.7 Business hours and days of operation;

3.10.8 A staff training and orientation plan and a staff education plan. Each facility shall maintain written records of these activities, including the names of persons attending, methods used, and an evaluation of their effectiveness;

3.10.9 A plan for staff pre-employment physical examinations and subsequent health examinations, including content and frequency;

3.10.10 Policies and procedures for the maintenance of personnel records for each employee, including at least his/her name, previous employment, educational background, license number and date of expiration (if applicable), staff orientation and education records, personnel evaluation, health examination records, and job descriptions; and

3.10.11 Policies and procedures for maintaining written staffing patterns and weekly duty schedules for each service.

3.11 The manual(s) referred to in 3.10-3.10.11 shall be available in the facility to all patients, staff, and the public, and to representatives of the Department at all times.

3.12 The facility shall have a written agreement for consultant services and for services not provided in the facility. The written agreement shall:

3.12.1 Be dated and signed by a representative of the facility and by the person or agency providing the service;

3.12.2 Include each party's responsibilities, functions, objectives, number of hours and days of the week the provider is in the facility, the financial arrangements and charges, and duration of the written agreement;

3.12.3 Specify that the facility retains administrative responsibility for the services rendered; and

3.12.4 Require compliance with the standards in this document.

3.13 Each consultant shall provide written documentation of each visit including, but not limited to, documentation of services rendered, problems noted, and recommendations made.

3.14 The facility shall have in effect a transfer agreement with one or more hospitals licensed by the Department such that inpatient care, and emergency services are available to the facility's patients. The transfer agreement shall:

3.14.1 Ensure the transfer of patients between the hospital and the facility whenever such transfer is ordered by a physician. In the event of an emergency, transfer may be made without a physician's order; and

3.14.2 Specify the type of patient records to be transferred with the patient, and the method and timetable for the transfer of such records.

3.15 The facility shall notify the Health Facilities Inspection Program of the Department immediately by telephone, followed within 72 hours by a written confirmation, of the following:

3.15.1 Expected or actual interruption or cessation of operations and/or services listed in the standards in this document, or of such other services as fuel, water, heat, gas, or electricity;

3.15.2 Termination of employment of the administrator and/or the program director and the name and qualifications of his/her replacement. If a new administrator and/or program director cannot be designated within 72 hours, the Department shall be so notified in writing and the facility shall make arrangements for administrative supervision and/or a program director. A new administrator and/or program director shall be appointed within 30 days;

3.15.3 Occurrence of epidemic disease in the facility;

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

3.15.5 All alleged or suspected crimes related to the patients receiving services, which shall be reported at the time of occurrence to the local police department, to the Health Facilities Inspection Program, and to the Office of the Ombudsman for Institutionalized Elderly, 13 North Warren Street, Trenton, New Jersey 08625.

3.16 The facility shall maintain on file written documentation of:

3.16.1 Annual inspection of the facility by the local fire authority;

3.16.2 Semi-annual inspection of the fire detection system by the installing company or a company approved by the Health Facilities Inspection Program of the Department;

3.16.3 Annual inspection of the elevator(s) by the local authority responsible for such inspection. If no local authority is responsible, the installing company or a company approved by the Department shall perform the inspection; and

3.16.4 Annual inspection of boiler and generator systems by a boilermaker or mechanic not on the staff of the facility.

3.17 The facility shall conspicuously post a notice that the following information is available in the facility, during business hours, to patients, staff, and the public:

3.17.1 All waivers granted by the Department;

3.17.2 The name and address of any person, partnership, or corporation having an ownership interest in the facility;

3.17.3 Any proposed change in ownership;

3.17.4 All records, reports, documents, policies, procedures, and manuals required by the standards in this document;

3.17.5 A list of deficiencies from the last annual licensure inspection and certification survey report (if applicable);

3.17.6 A list of the facility's committees;

3.17.7 The names and addresses of members of the governing authority;

3.17.8 Any changes of membership of the governing authority, within 30 days of the change;

3.17.9 Policies and procedures regarding patient rights, obligations, and prohibitions, as set forth in N.J.S.A. 30:13-1 et seq.; and

3.17.10 Copies of the documents listed in 3.17 through 3.17.9, which shall be provided upon request

within a reasonable time and at a reasonable charge payable in advance.

3.18 Except in an emergency, facilities shall not operate more than 12 hours during each calendar day of the year without prior written approval by the Department.

## 4.0 Governing Authority

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

4.1.1 Services provided in the facility and the quality of care rendered to patients;

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

4.1.3 Adoption and documented annual review of written bylaws, the budget, and patient rights;

4.1.4 Written confirmation of appointments made by the governing authority;

4.1.5 Formulation and documented annual review of personnel policies and patient care policies;

4.1.6 Establishment of staff committees;

4.1.7 Determination of the frequency of meetings of the governing authority, holding such meetings, and documenting them through minutes, including a record of attendance; and

4.1.8 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 that action was taken.

4.2 The governing authority shall appoint an administrator, a full-time program director, and a registered nurse. The program director and registered nurse shall be available on the premises of the medical day care facility during the facility's hours of operation.

4.3 The full-time program director may also serve in a dual capacity as the registered nurse, occupational therapist, physical therapist, speech-language pathologist, social worker, or patient activities consultant. However, he/she shall not be counted more than once in the staff:patient ratio of one staff member for every nine patients, calculated on the basis of daily census.

## 5.0 Administration

5.1 The governing authority shall appoint an administrator.

5.2 The administrator shall be accountable to the governing authority.

5.3 An alternate shall be designated in writing to act in the absence of the administrator.

5.4 The governing authority shall appoint a full-time program director who shall be on the premises during the facility's hours of operation.

5.5 In a facility with a daily capacity of fewer than 60 medical day care patients, the administrator may serve as program director if he/she meets the qualifications as stated in 1.61.

5.5.1 The administrator of two or more facilities licensed by the Department shall not serve as a program director.

5.6 In a facility with a daily capacity of 60 or more medical day care patients, both an administrator and a full-time program director shall be appointed.

5.7 In the event a program director is appointed, he/she shall be accountable to the administrator.

5.8 An alternate shall be designated in writing to act in the absence of the program director.

5.9 The administrator shall be responsible for, but not limited to, the following:

5.9.1 Planning for and administration of the management, operational, fiscal, and reporting components of the facility;

5.9.2 Ensuring the development, implementation, and enforcement of all policies and procedures, including patient rights;

5.9.3 Employing and placing all staff within the facility and ensuring that no staff member shall be counted more than once in the staff:patient ratio of one staff member for every nine patients, calculated on the basis of daily census;

5.9.4 Ensuring the provision of staff education and orientation;

5.9.5 Ensuring that a file is maintained for each staff member, including at least his/her name, previous employment, educational background, license number and date of expiration (if applicable), staff orientation and education records, personnel evaluation, health examination records, and job descriptions;

5.9.6 Participating in policy and administrative decision-making;

5.9.7 Administering and supervising the non-clinical operations of the program;

5.9.8 Acting as a liaison to the governing authority on behalf of the medical director, the patients, and the staff;

5.9.9 Within 30 days of a patient's discharge, ensuring that the patient care plan, the discharge summary, and the discharge plan are provided in the medical record; and

5.9.10 Together with the medical director, developing and implementing procedures for:

5.9.10.1 Maintaining administrative relationships, communication, and integration with support services and community resources; and

5.9.10.2 Communicating with staff through group meetings, individual conferences, written memoranda, and/or other methods of exchanging information.

5.10 The program director shall be responsible for, but not limited to, the following:

5.10.1 Developing the program in accordance with the needs of the patients served;

5.10.2 Ensuring the implementation and coordination of the program;

5.10.3 Evaluating the patients' changing needs and making necessary program adjustments; and

5.10.4 Supervising staff.

## 6.0 Patient Care Policies and Procedures

6.1 The facility shall establish, implement, and perform a documented review at least annually of the written policies and procedures, approved by the Department, governing the provision of services.

6.2 All patient care policies and procedures shall be available to patients, staff, and the public.

6.3 The administrator shall be responsible for ensuring the development, implementation, and enforcement of all patient care policies.

6.4 The facility shall have in effect written patient care policies and procedures which shall include, but not be limited to, the following:

6.4.1 A description of the manner in which the facility utilizes a multidisciplinary team approach in providing medical day care services to patients;

6.4.2 A description of the specific services provided;

6.4.3 Enumeration of patient rights;

6.4.4 A description of the facility's policies regarding the criteria for the admission, discharge, and transfer of patients;

6.4.5 Assignment of duties to staff in accordance with written job descriptions;

6.4.6 A description of the transportation services for patients to and from their homes and to services provided indirectly by the facility to implement the patient's plan of care. No patient's total daily transportation time shall exceed two hours;

6.4.7 The appointment of one full-time medical day care staff member for every nine patients, calculated on the basis of daily census;

6.4.7.1 The medical director shall not be counted in the staff:patient ratio;

6.4.7.2 The staff:patient ratio shall not include patients other than medical day care patients;

6.4.8 The availability of backup (substitute) staff with equivalent qualifications to take the place of each staff member in order to maintain the staff:patient ratio in the event that one or more staff members are absent;

6.4.9 The provision of at least one bed, lounge, recliner, or equivalent approved by the Department, for every ten medical day care patients, calculated on the basis of daily census;

6.4.10 The provision of a dining area to accommodate all medical day care patients simultaneously;

6.4.11 A definition of emergency and a written plan for the care to be provided to the patient(s) in the event of an emergency. The policies and procedures shall include the name and telephone number of a physician on call, written agreements with a hospital for inpatient and emergency room services, and provision for transportation to a hospital;

6.4.12 Plans of care for patients during an episode of communicable disease, for patients with tuberculosis whose disease is not communicable following initiation of chemotherapy or whose disease is non-respiratory and therefore not transmissible;

6.4.13 A description of financial arrangements to ensure that the payor is informed in writing of the basic rates and any additional charges, expenses, or other financial liabilities and of the person or third party payor who will be billed for the service;

6.4.14 Prohibitions on the use of any type of restraint, including physical and chemical restraints;

6.4.15 Procedures for and assignment of responsibility for maintenance of records as required by these standards;

6.4.16 Procedures regarding verbal and telephone orders to ensure that they are accepted only by personnel authorized under the laws or regulations of the State of New Jersey, written into the patient's medical record by the person

accepting them, and countersigned by the physician within 48 hours;

6.4.17 Procedures regarding stop orders for medical and laboratory services, indicating length of time orders may be in effect;

6.4.18 Provision for podiatric services, dental and emergency dental services, eye examinations, eye glasses, audiologic evaluation, and hearing aids. These services need not be provided on the premises, but the medical day care facility shall assist the patient by arranging for an appointment, transportation to and from the services, and escort service if needed;

6.4.19 Admission procedure ensuring that:

6.4.19.1 A patient is admitted only on a physician's written orders documenting the medical day care services needed;

6.4.19.2 Prior to or upon admission, the patient designates in writing a physician to attend the patient for periodic and emergency visits and a person to be notified in case of an emergency. The patient and/or the patient's physician shall also designate in writing an alternate physician or plan for attending the patient when the patient's physician is not available. The facility shall ensure that the patient agrees to authorize the administrator to arrange for another physician in an emergency if neither the patient's physician nor alternate physician is available;

6.4.19.3 Prior to or upon admission of the patient, the administrator or his/her designee conducts a personal interview with the patient and the patient's family. A summary of all interviews shall be recorded in the patient's medical record;

6.4.19.4 Prior to or upon admission of the patient, the patient's physician completes a medical care plan;

6.4.19.5 Prior to admission of the patient, a member of the multidisciplinary team or a public health nurse or a representative of a social service or health agency approved by the Department visits the patient's home and completes a written assessment of the patient's home

environment. The assessment shall be recorded in the patient's medical record and shall include:

6.4.19.5.1 Living arrangements;

6.4.19.5.2 Patient's relationship with family or other person;

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

6.4.19.5.4 Existence of environmental barriers such as stairs or other environmental conditions not negotiable by the patient; and

6.4.19.5.5 Access to transportation, shopping, religious, social, or other resources to meet the needs of the patient;

6.4.19.6 Prior to or upon admission of the patient, the multidisciplinary team initiates an individualized patient care plan developed in conjunction with and approved in writing by the patient's physician, and based upon the medical care plan and the home environment assessment;

6.4.20 Restrictions on the admission and retention of patients, to ensure that:

6.4.20.1 Patients under sixteen years of age are not admitted;

6.4.20.2 Patients who manifest such a degree of behavioral disorder that they are a danger to themselves or others, or whose behavior interferes with the health or safety of other patients, are not admitted or retained;

6.4.20.3 Patients diagnosed as being drug or alcohol abusers are not admitted to or retained in the facility, unless the patient has another diagnosed illness or illnesses;

6.4.20.4 If the facility is not of fire-resistive construction, patients who are blind or require supervision or assistance to ambulate stairs and patients with a walker, crutch(es), or leg brace(s) are restricted to the first floor of the facility; and

6.4.20.5 Patients who require wheelchairs are restricted to the first floor of the facility. A facility which has been granted any physical plant waiver by the Department shall not be permitted to admit a patient requiring a wheelchair;

6.4.21 Rules for smoking, to ensure compliance with the provisions of Chapter 15 of the New Jersey State Sanitary Code (N.J.S.A. 26:12 1A-7 et seq. and N.J.A.C. 8:15-1 et seq.); and

6.4.22 Procedures for interpretation, if the patient population is non-English-speaking, or for patients who are blind or deaf.

6.5 If a patient does not appear for transportation or does not come to the facility on a scheduled day of attendance, follow-up shall be made immediately by the facility to determine the reason. The findings of the follow-up and the action taken by the facility shall be documented in the patient's medical record.

## 7.0 Medical Service

7.1 The governing authority shall appoint a physician to serve as medical director who shall be responsible for the direction, provision, and quality of medical care provided.

7.2 The medical director shall be directly or indirectly accountable to the governing authority.

7.3 The medical director shall be responsible for, but not limited to, the following:

7.3.1 Delineating the responsibilities of attending physicians;

7.3.2 Communicating with attending physicians to ensure that a written medical care plan is completed prior to or upon the patient's admission and is kept current;

7.3.3 Establishing written policies for utilization of medical consultant and specialist services;

7.3.4 Monitoring the health status of the facility's personnel;

7.3.5 Providing documented investigation of incidents and accidents that occur on the premises, in order to identify and correct hazards to health and safety;

7.3.6 Providing documented information to the administrator, in order to ensure a safe and sanitary environment for patients and personnel;

7.3.7 With the administrator, assuming responsibility for the execution of patient care policies;

7.3.8 Participating in the development and direction of ongoing staff educational programs;

7.3.9 Developing and maintaining a system of medical audit and evaluation of patient care; and

7.3.10 Participating or ensuring physician representation on staff committees.

7.4 The medical director shall not be counted in the staff:patient ratio.

7.5 The administrator or his/her designee shall:

7.5.1 Verify that the patient's medical record contains the name, address, and telephone number of the attending physician and the person to be notified in an emergency;

7.5.2 Notify the attending physician whenever a physician visit is required by the patient or in an emergency;

7.5.3 Assist in the development of and implement written procedures to provide emergency medical care. The written procedures and a list of physicians available to provide emergency medical care shall be posted at each nurses' area; and

7.5.4 In the event of an emergency, ensure that the person who has been designated by the patient to be notified in an emergency is notified no more than three hours after the occurrence of an accident or of deterioration in the patient's condition, and that the notification is documented in the medical record.

7.6 The patient's attending physician shall agree:

7.6.1 To be called in an emergency;

7.6.2 Prior to or upon the patient's admission, to write a medical care plan, which shall be reviewed and revised in accordance with a schedule which he/she justifies and documents in the patient's medical record;

7.6.3 To approve a written patient care plan developed in conjunction with the multidisciplinary team. This plan shall be initiated prior to or upon admission of the patient and shall be reviewed and revised as necessary, in accordance with a schedule which he/she and individual team members justify and document in the patient's medical record;

7.6.4 To write, sign, and date a progress note at the time he/she attends the patient;

7.6.5 To provide an admission history and physical examination;

7.6.6 To provide in writing initial and subsequent orders for services to be provided to the patient, including the frequency, duration,

and modality of the services to be provided in the medical day care facility and the frequency with which the patient shall be seen by the physician; and

7.6.7 To write the medical portion of the discharge summary and discharge plan.

7.7 Prior to or upon the admission of the patient, the facility shall obtain from the attending physician and shall document in the patient's medical record, the following:

7.7.1 A signed, dated admission and medical history and a report of physical examination, including results of chest X-ray (at the discretion of the physician), diagnoses, and rehabilitation potential. Patients under age 35 shall also have an intradermal tuberculin test (and follow-up if necessary), with the exception of positive tuberculin reactors, who shall have a chest X-ray given within a period of time specified and documented by a physician in the patient's medical record. The history and examination shall be performed within five days prior to or upon admission;

7.7.2 Written documentation that the patient:

7.7.2.1 Does not require 24-hour inpatient or residential health care;

7.7.2.2 Is mobile under his/her own power, with or without assistive devices (see 1.4) and is able to leave the building by him/herself; and

7.7.2.3 Is free of communicable disease and needs the services provided by the medical day care facility.

7.7.3 The medical care plan, which shall be reviewed and revised as necessary in accordance with a schedule which is justified and documented in the patient's medical record; and

7.7.4 Approval of the patient care plan which was developed in conjunction with the multidisciplinary team, and which shall be reviewed and revised as necessary by the physician and the multidisciplinary team in accordance with a schedule justified and documented by the physician and the team members in the medical record.

## 8.0 Nursing Services

8.1 The facility shall provide nursing services during all hours of operation.

8.2 The facility shall maintain the organization, management, and operation of nursing services in accordance with a written organizational plan which shall describe the responsibility, authority, and accountability relationships of personnel, the functional structure of the service, and the relationship of the nursing service to other services.

8.3 At least one registered professional nurse shall be assigned to the medical day care facility premises to provide patient care at all times during its hours of operation.

8.4 A licensed practical nurse shall function under the direction of a registered professional nurse or a licensed or otherwise legally authorized physician or dentist.

8.5 The facility shall ensure that the duties and responsibilities of levels and types of nursing personnel are described in the job descriptions and in the policy and procedure manual of the nursing service, and that personnel are assigned duties based upon their education and training.

8.6 Nursing and ancillary personnel shall ensure that each patient:

8.6.1 Has a written patient care plan, coordinated and maintained by the nursing service and implemented upon admission;

8.6.2 Receives treatments, medications, care, and diets, as ordered by the physician; and

8.6.3 Receives care toward prevention of infection, accident, and injury.

8.7 The facility shall have on duty during all hours of operation a registered professional nurse designated in writing as the director of nursing services. The director of nursing may provide direct nursing care to patients. An alternate registered professional nurse shall be designated in writing to act in the absence of the director of nursing services.

8.7.1 In the event that the director of nursing services is also designated as the program director, at least one additional licensed nurse shall be assigned to the medical day care facility premises at all times during its hours of operation.

8.8 The director of nursing services shall be responsible for, but not limited to, the direction, provision, and quality of nursing care provided and for the following:

8.8.1 Developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the nursing service;

8.8.2 Participating in total planning and budgeting for the nursing service, including recommending to the administrator the number and levels of nursing and ancillary personnel to be employed;

8.8.3 Coordinating and integrating the nursing service with other patient care services;

8.8.4 Participating in staff committees;

8.8.5 Maintaining working relationships with administration through conferences, written memoranda, and other methods of exchanging information;

8.8.6 Developing and maintaining written job descriptions for nursing and ancillary personnel;

8.8.7 Selecting for employment, designing staffing patterns for, and assigning duties to all nursing and ancillary personnel;

8.8.8 Ensuring supervision and evaluation of nursing and ancillary personnel;

8.8.9 Assisting in the development of, and participating in, staff orientation and educational programs for the nursing service, and documenting these activities;

8.8.10 Ensuring that a registered professional nurse prepares an individual nursing care plan for each patient upon admission, reassesses the nursing needs of each patient as needed in accordance with a schedule which he/she

justifies and documents in the patient's medical record, writes clinical notes, and writes progress notes indicating the patient's response to nursing care in accordance with a schedule which the registered professional nurse justifies and documents in the patient's medical record; and

8.8.11 At the time of discharge, ensuring that the nursing portion of the patient care plan, the nursing care plan, and the nursing portions of the discharge summary and discharge plan are provided in the patient's medical record.

8.9 In accordance with written job descriptions, nursing and ancillary personnel shall be responsible for, but not limited to, the following:

8.9.1 Providing direct nursing care;

8.9.2 Administering medications and/or treatments to patients upon written order of a physician, in accordance with the State of New Jersey Nursing Practice Act and the standards set forth in Sections 7.0 and 9.0. Only the following nursing personnel shall be permitted to administer medications:

8.9.2.1 Registered professional nurses;

8.9.2.2 Licensed practical nurses who have undergone formal training in the administration of medications, in programs approved by the New Jersey State Board of Nursing;

8.9.2.3 Nurses with valid "permission to work" letters issued by the New Jersey State Board of Nursing (N.J.A.C. 13:37-3.5; 13:37-4.6; 13:37-10.4; and 13:37-11.5). (The aforementioned excludes foreign exchange visitor nurses);

8.9.2.4 Unlicensed nurses who are graduates of domestically accredited nursing schools, pending the results of the first two consecutive licensing examinations immediately following the completion of their nursing program (N.J.A.C. 13:37-2.7 and 13:37-9.5); and

8.9.2.5 Student nurses in a school of nursing approved by the New Jersey State Board of Nursing, under the direct supervision and within immediate view of a registered professional nurse;

8.9.3 Assessing the needs of each patient and developing, reviewing, revising, and implementing the nursing portion of the patient care plan to meet those needs;

8.9.4 Assisting patients who need help with meals. Nursing and/or ancillary personnel shall be in the dining area during each meal;

8.9.5 Assessing, observing, and monitoring the patient's response to treatment and nursing care;

8.9.6 Coordinating nursing care with other patient care services;

8.9.7 Monitoring the patient's vital signs as defined in the facility's policies or as ordered by a physician;

8.9.8 Monitoring daily functioning level of patients including, but not limited to, rest, recreation, and exercise;

8.9.9 Teaching, supervising, and consulting with other personnel, the patient, and family members regarding methods of meeting the nursing care needs and other related problems of the patient. (Licensed nursing personnel only shall perform these functions);

8.9.10 Encouraging patients to achieve independence in activities of daily living by teaching self-care, transfer, and ambulation activities, as defined in 1.1;

8.9.11 Assisting patients to use their prosthetic devices in accordance with a physician's instructions;

8.9.12 Assisting patients to carry out prescribed rehabilitation therapy between visits of the therapist;

8.9.13 Providing patients with training in self-administration of medications when self-administration has been authorized in writing by the patient's physician and documented in the medical record;

8.9.14 Coordinating reality orientation for patients, integrated with other patient care services; and

8.9.15 Coordinating and maintaining the patient care plan in accordance with a schedule which the physician justifies and documents in the patient's medical record.

8.10 In accordance with written job descriptions and with the standards in this document, nursing personnel shall enter in the patient's medical record:

8.10.1 The nursing care plan. This shall be reviewed and revised in accordance with a schedule which is justified and documented in the patient's medical record;

8.10.2 Clinical notes;

8.10.3 Progress notes, in accordance with a schedule which the nurse justifies and documents in the patient's medical record;

8.10.4 The nursing portion of the discharge summary and discharge plan;

8.10.5 A record of medication. After each administration of medication, the following shall be documented: name and strength of the drug, date and time of administration, dosage administered, route of administration, and signature of the licensed nurse administering the drug. Initials may be used after the licensed nurse's signature appears at least once on each page of the documentation; and

8.10.6 In the event that the patient is authorized in writing by his/her physician to self-administer his/her medication, the record of the self-administration of medication shall be based upon the policies and procedures developed by the facility and approved by the Department.

## 9.0 Pharmaceutical Services

9.1 The facility shall provide pharmaceutical services either directly or through written agreement.

9.2 The facility shall maintain the organization, management, and operation of pharmaceutical services in accordance with a written organizational plan which shall describe the responsibility, authority, and accountability relationships of personnel, the functional structure of the service, and the relationship of the pharmaceutical service to other services.

9.3 The facility shall have in writing and review annually policies (including stop order policies), procedures, and methods for obtaining, dispensing, storing, administering, self-administering, and usage of medications and biologicals, developed with the advice of a Pharmaceutical Services Committee. The Committee shall consist of, but not be limited to, the medical director or a physician, the administrator, a member of the nursing service, and either a staff or consulting pharmacist.

9.4 The facility shall allow patients to bring medication into the facility for the purpose of self-administering medication if authorized in writing by the patient's physician and documented in the patient's medical care plan. The patient's physician shall document in the patient's medical care plan the name, strength, and dosage of the drug(s) to be self-administered and the directions for use.

9.4.1 The facility shall develop and implement policies and procedures regarding the self-administration of medications and the bringing of medications by patients to the facility for the purpose of self-administration. These policies and procedures shall include, but not be limited to:

9.4.1.1 Storage of medications;

9.4.1.2 Labeling of medications;

9.4.1.3 While the patient is in the facility, documenting in the patient's medical record that the patient self-administers his/her medications at the prescribed time; and

9.4.1.4 Providing training to patients in the self-administration of medications and documenting such in the medical record.

9.4.2 The written policies and procedures shall ensure that patients do not share their medications and do not take other patient's medications.

9.5 The facility shall ensure that:

9.5.1 Medications that are not self-administered are prescribed in writing, the medications are administered by licensed or authorized personnel, in accordance with the State of New Jersey Medical and Nursing Practice Acts and the New Jersey Administrative Code for the State Board of Pharmacy, and medication cards or other systems approved by the Department are used;

9.5.2 Drug reactions and/or allergies are documented in the patient's medical record and on its outside front cover;

9.5.3 Medications prescribed for one patient are not administered or self-administered to another patient;

9.5.4 Medication errors (including errors in self-administration) and drug reactions are immediately reported to the patient's attending physician, the pharmacist(s), the administrator, and the director of nursing, and an entry thereof made in the patient's medical record as well as on an incident report. The Pharmaceutical Services Committee shall review all incidents relating to drugs;

9.5.5 A current medication reference text and sources of information, as designated by the Pharmaceutical Services Committee, concerning drugs, their indications, actions, reactions, interactions, contraindications, cautions, precautions, and dosage are available in each nurses' area;

9.5.6 If non-legend drugs are maintained as stock by the facility, they are stored in a locked cabinet, closet, or room and are not stored with legend drugs or disinfectants, insecticides, bleaches, rubbing alcohol, poisons, and/or substances for external use only, and they are permanently labeled to include drug

names, manufacturer, lot number, expiration date, and cautionary or accessory labeling; and

9.5.7 If pharmaceutical services are not provided directly by the facility but are provided through written agreement, the telephone number of the pharmacy shall be posted in the nursing area.

9.6 If the facility maintains an institutional pharmacy, the pharmacy shall be licensed by the New Jersey State Board of Pharmacy and the facility shall employ a pharmacist registered by the New Jersey State Board of Pharmacy.

9.7 If the facility does not have a licensed institutional pharmacy to provide direct pharmaceutical services, the facility shall appoint a pharmacist as consultant.

9.8 The staff or consultant pharmacist shall be responsible for the direction, provision, and quality of the pharmaceutical services provided. He/she shall be responsible for, but not limited to, the following:

9.8.1 Together with the Pharmaceutical Services Committee, developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the pharmaceutical service;

9.8.2 Participating in planning and budgeting for the pharmaceutical service;

9.8.3 Coordinating and integrating the pharmaceutical service with other patient care services;

9.8.4 Participating in staff committees;

9.8.5 Maintaining working relationships with administration through conferences, written memoranda, and other methods of exchanging information;

9.8.6 Assisting in the development of and participating in staff orientation and educational programs for the facility and the pharmaceutical service, and documenting these activities;

9.8.7 Preparing, reviewing, dating, and signing the pharmacy consultation sheet in the medical record of each patient in accordance with a schedule which the consultant justifies and documents in the patient's medical record, and noting any problems such as interactions or wrong dosages;

9.8.8 Providing to the Pharmaceutical Services Committee a quarterly summary of the status of the facility's pharmaceutical services and an analysis of any incident reports relating to drug therapy;

9.8.9 Providing pharmaceutical guidance to other personnel responsible for patient care; and

9.8.10 Ensuring that for medication administered by authorized personnel of the facility:

9.8.10.1 The label of each patient's individual medication container is permanently affixed and clearly indicates the patient's full name, physician's name, prescription number, name and strength of drug, date of issue, manufacturer's expiration date of all time-dated medications, name, address, and telephone number of the pharmacy issuing the drug, lot number, manufacturer's name, and cautionary and/or accessory labels. If a unit dose system is used, cautionary instructions shall appear on the patient's medication record;

9.8.10.2 Medications in containers having soiled, damaged, incomplete, illegible, or makeshift labels are returned to the issuing pharmacist or pharmacy for relabeling, disposal, or destruction, and medications in containers having no labels are destroyed in accordance with state and federal laws;

9.8.10.3 Medications for individual patients are kept and stored in the original prescription containers, and there is no transferring between containers;

9.8.10.4 Medications requiring refrigeration are 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 nurses' area. The refrigerator shall have a thermometer to indicate temperature in conformance with U.S.P. (United States Pharmacopoeia) requirements;

9.8.10.5 Poisons and medications for external use only are kept in a locked cabinet or room and separate from other medications;

9.8.10.6 Medications which the physician's written orders do not specifically limit as to time or number of doses are automatically stopped, in accordance with the stop order policies developed by the Pharmaceutical Services Committee;

9.8.10.7 Outdated medications or medications no longer in use are returned to the pharmacy and/or disposed of or destroyed within 30 days and in accordance with state and federal laws and regulations, and the action taken documented and signed in the patient's medical record. Action taken on controlled dangerous drugs shall also be documented and signed in a log or file kept for that purpose;

9.8.10.8 Medications having an expiration date are removed from use on that date, disposed of after such date, and the disposal documented, as prescribed by law; and

9.8.10.9 All medications are kept in locked storage areas.

9.9 The control of drugs subject to the Controlled Dangerous Substances Act of 1970 shall be in full compliance with all federal and state laws and regulations concerning procurement, storage, dispensing, administration, and disposition.

9.9.1 An individual record shall be maintained for each type and strength of medication subject to the aforementioned Act. The following shall be recorded: name of the patient receiving the medication, physician's name, prescription number, name and strength of the drug, date received from the pharmacy, date and time of administration, dosage administered, route of administration, signature of the licensed nurse administering the drug, amount of medication remaining, amount of medication wasted (when appropriate), and the signature of the nurse witnessing the destruction of medication wasted (when appropriate). At the termination of each tour of duty, the inventories shall be verified and the record shall be signed by both incoming and outgoing licensed nurses.

9.9.2 The facility shall have written policies and procedures to be followed in the event that the inventories cannot be verified or drugs are lost, contaminated, or destroyed. A report of any such incident shall be written and signed by the licensed nurses involved and any witnesses present, and copies shall be sent for review to the administrator, the director of nursing services, the consultant pharmacist, the pharmacy issuing drugs to the facility, and the Pharmaceutical Services Committee.

9.9.3 Medications subject to the Controlled Dangerous Substances Act of 1970, Classes III, IV, and V, shall be kept in a locked medication cabinet, medication room, or mobile medication cart, and separate from noncontrolled drugs.

9.9.4 Medications subject to the Controlled Dangerous Substances Act of 1970, Class II, shall be stored in a separate locked box or drawer within the locked medication cabinet, medication room, or mobile medication cart, and separate from noncontrolled drugs.

9.9.5 Medications subject to the Controlled Dangerous Substances Act of 1970, Classes II, III, IV, and V, may be stored in the same locked medication cabinet, medication room, or mobile medication cart if Class II medications are stored in a separate locked box in the locked medication cabinet, medication room, or mobile medication cart.

9.9.6 Exceptions may be made to the storage requirements of medications subject to the aforementioned Act if the facility uses a unit dose system.

## 10.0 Dietary Services

10.1 The medical day care facility shall provide dietary services, either directly or through written agreement. If a commercial food management firm provides dietary services, it shall be required to conform to these standards.

10.2 The facility shall provide a minimum of one meal per day. The meal shall supply at least one-third (1/3) of the daily caloric and protein requirements recommended by the Nutrition Board of the National Academy of Sciences, National Research Council, and shall contain three or more menu items, one of which is or shall include a high quality protein food such as meat, fish, eggs, or cheese.

10.3 Therapeutic diets and supplemental feedings shall be made available according to the physician's orders as documented in the patient's medical record.

10.4 The facility shall maintain the organization, management, and operation of dietary services in accordance with a written organizational plan which shall describe the responsibility, authority, and accountability relationships of personnel, the functional structure of the service, and the relationship of the dietary service to other services.

10.5 The facility shall provide:

10.5.1 A current diet manual approved by the dietitian and the Department, and located in the dietary department;

10.5.2 Diets, served to patients, that are consistent with the diet manual; and

10.5.3 Observation and documentation in the patient's medical record of meals refused or missed.

10.6 All patients shall eat in a dining area with sufficient space to accomodate all patients simultaneously at each meal.

10.7 The facility and its personnel shall comply with the provisions of Chapter 12 of the New Jersey State Sanitary Code (N.J.S.A. 24:15-1 et seq. and N.J.A.C. 8:24-1 et seq.).

10.8 The facility shall ensure that the dietary service:

10.8.1 Selects food and drink and prepares menus with regard for the nutritional and therapeutic needs, cultural backgrounds, food habits, and personal food preferences of patients;

10.8.2 Develops and uses written and dated menus, planned at least seven days in advance by a dietitian, for all diets, and does not use the same menu more than once in one week;

10.8.3 Posts current menus, including portion sizes, in the food preparation area, and posts any changes in menus. Menus, with changes, shall be kept on file in the dietary department for at least 30 days;

10.8.4 Adheres to written policies, approved by the Department, regarding meal hours, menus, and serving portions of the meal as between-meal nourishment;

10.8.5 Provides between-meal nourishments for each patient, unless contraindicated by a physician as documented in the patient's medical record;

10.8.6 Offers substitute foods and drinks to all patients who refuse the food served at meal-times. Such substitutes shall be of equivalent nutritional value;

10.8.7 Prepares food by cutting, chopping, grinding, or blending to meet the needs of each patient; and

10.8.8 Provides self-help feeding devices.

10.9 The facility shall appoint a dietitian on a full-time, part-time, or consultant basis. The dietitian shall provide dietary services a minimum of four hours per month.

10.10 The dietitian shall be responsible for the direction and quality of the dietary care provided. He/she shall be responsible for, but not limited to, the following:

10.10.1 Developing written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the dietary service;

10.10.2 Assessing the nutritional needs of each patient, preparing an individual dietary care plan, and reassessing the patient's response

to dietary services in accordance with a schedule which the dietitian justifies and documents in the patient's medical record;

10.10.3 Reviewing and approving all menus used;

10.10.4 Providing or recommending sources and use of standardized recipes, adjusted to appropriate yield;

10.10.5 Providing nutritional guidance and consultation to other patient care personnel;

10.10.6 Participating in developing, reviewing, and revising the dietary portion of patient care and discharge plans;

10.10.7 Providing dietary counseling to patients and their families;

10.10.8 Developing and maintaining written job descriptions for dietary personnel;

10.10.9 Recommending to the administrator the number and levels of dietary personnel to be employed; and

10.10.10 Assisting in selecting for employment, assigning duties to, supervising, and evaluating all dietary personnel.

10.11 The facility shall appoint a food service supervisor who, if not a dietitian, functions with scheduled consultation from a dietitian. In facilities with 60 or more patients, calculated on the basis of a daily census, a full-time food service supervisor shall be appointed.

10.12 The food service supervisor, under the direction of a dietitian, shall be responsible for, but not limited to, the following:

10.12.1 Implementing written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the dietary service;

10.12.2 Participating in planning and budgeting for the dietary service, including developing methods of food cost control;

10.12.3 Coordinating and integrating the dietary service with other patient care services;

10.12.4 Participating in staff committees;

10.12.5 Maintaining working relationships with administration through conferences, written memoranda, and other methods of exchanging information;

10.12.6 Assisting in the development of, and participating in, staff orientation and educational programs for the facility and the dietary service, and documenting these activities;

10.12.7 Maintaining a record of all patients, identified by name, diet order, and such other information as food likes and dislikes, allergies, and meal patterns when on a calculated diet. Such identification shall be available in the dining area;

10.12.8 Ensuring that therapeutic diets as ordered by a physician are served, and that no patient receives a therapeutic diet except as ordered by a physician;

10.12.9 Establishing and maintaining a method of recording and transmitting diet orders and changes received from the nursing service;

10.12.10 Maintaining a file of recipes for menu items, adjusted to yield, which shall be used in preparing foods listed on the posted menus;

10.12.11 Recommending the quantity, kinds, and variety of food and supplies to be purchased; and

10.12.12 Providing a monthly summary, including, but not limited to, the following:

10.12.12.1 Records of weekly menus of all diets served to patients; and

10.12.12.2 The numbers and kinds of diets served daily to patients.

10.13 The dietitian or consultant dietitian shall enter in the patient's medical record:

10.13.1 The dietary care plan. This shall be reviewed, and revised as necessary, by the dietitian or consultant dietitian in accordance with a schedule which he/she justifies and documents in the patient's medical record;

10.13.2 Clinical notes;

10.13.3 Progress notes, written in accordance with a schedule which the dietitian or consultant dietitian justifies and documents in the patient's medical record; and

10.13.4 The dietary portion of the discharge summary and discharge plan.

## 11.0 Rehabilitation Services

11.1 The facility shall provide, directly or through written agreement, physical therapy, occupational therapy, and speech-language pathology and audiology services when prescribed by a physician.

11.2 The facility shall maintain the organization, management, and operation of rehabilitation therapy services in accordance with a written organizational plan which shall describe the responsibility, authority, and accountability relationships of personnel, the functional structure of the service, and the relationship of the rehabilitation service to other services.

11.3 The facility shall appoint a supervisor for each rehabilitation service offered, who shall be responsible for the direction, provision, and quality of the rehabilitative care provided. He/she shall be responsible for, but not limited to, the following:

11.3.1 Developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the rehabilitation service;

11.3.2 Participating in planning and budgeting for the rehabilitation service, including recommending to the administrator the number and levels of rehabilitation personnel to be employed;

11.3.3 Coordinating and integrating the rehabilitation service with other patient care services;

11.3.4 Participating in staff committees;

11.3.5 Maintaining working relationships with administration through conferences, written memoranda, and other methods of exchanging information;

11.3.6 Developing and maintaining written job descriptions for rehabilitation personnel;

11.3.7 Assisting in selecting for employment, assigning duties to, supervising, and evaluating all rehabilitation service personnel;

11.3.8 Assisting in the development of and participating in staff orientation and educational programs for the facility and the rehabilitation service, and documenting these activities; and

11.3.9 Ensuring that the rehabilitation personnel assess the rehabilitation needs of each patient upon orders of a physician, prepare an individual rehabilitation care plan, and reassess the patient's response to rehabilitation services in accordance with a schedule which the therapist, speech-language pathologist, and/or audiologist justifies and documents in the patient's medical record.

11.4 Each therapist, speech-language pathologist, and audiologist shall be responsible for, but not limited to, the following:

11.4.1 Assessing the degree of functioning and disability of the patient receiving the service, preparing an individual rehabilitation care plan, and, with a physician, reassessing the patient's response to treatment in accordance with a schedule which the therapist, speech-language pathologist, and/or audiologist justifies and documents in the patient's medical record;

11.4.2 Providing treatment services as specified in the rehabilitation care plan, and reporting the patient's responses to the physician within 14 days of the initiation of rehabilitation therapy;

11.4.3 Providing rehabilitation guidance and consultation to other patient care personnel;

11.4.4 Developing a maintenance rehabilitation regimen for the patient when approved by the physician, instructing other patient care personnel in its procedures, and reevaluating and revising the maintenance regimen, as indicated in the rehabilitation care plan; and

11.4.5 Participating in developing, reviewing, and revising the rehabilitation portion of the patient care and discharge plans of patients receiving rehabilitation services.

11.5 Each therapist, speech-language pathologist, and audiologist providing services to the patient shall enter in the patient's medical record:

11.5.1 The rehabilitation care plan. This shall be reviewed, and revised as necessary, by the therapist, speech-language pathologist, and/or audiologist in accordance with a schedule justified and documented in the patient's medical record;

11.5.2 Clinical notes;

11.5.3 Progress notes, written in accordance with a schedule which the therapist, speech-language pathologist, and/or audiologist justifies and documents in the patient's medical record; and

11.5.4 The rehabilitation portion of the discharge summary and discharge plan.

## 12.0 Social Work Services

12.1 The facility shall provide social services directly or through written agreement, including, but not limited to, guidance and/or referral in social, financial, and legal matters, assistance with housing relocation, shopping, and counseling on available community resources.

12.2 The facility shall maintain the organization, management, and operation of social work services in accordance with a written organizational plan which shall describe the responsibility, authority, and accountability relationships of personnel, the functional structure of the service, and the relationship of the social work service to other services.

12.3 The facility shall ensure visual and auditory privacy for social service interviews with patients and their families and/or sponsors and/or guardians.

12.4 The facility shall appoint a social worker, or a designee who receives onsite consultation from a social worker. A social worker or designee shall provide social work services in the facility at least one hour per week for every two patients. Social work consultation to the designee shall be at least two hours per week in facilities with more than 60 patients. Facilities with 60 or fewer patients shall have at least four hours of social work consultation per month.

12.5 The social worker shall be responsible for, but not limited to, the following:

12.5.1 Providing social work guidance and consultation to other patient care personnel;

12.5.2 Ensuring that social service personnel assess the social needs of each patient, reassess each patient's social service needs in accordance with a schedule which the social worker justifies and documents in the patient's medical record, and prepare an individual social service care plan if the assessment or reassessment indicates a need for social services;

12.5.3 Developing written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the social work service. This shall include policies and procedures for the use and coordination of social services available through hospitals, community health programs, and community social agencies;

12.5.4 Developing and maintaining written job descriptions for social service personnel;

12.5.5 Recommending to the administrator the number and levels of social service personnel to be employed; and

12.5.6 Assisting in selecting for employment, assigning duties to, supervising, and evaluating all social service personnel.

12.6 The social worker, or the designee under the direction of the social worker, shall be responsible for the direction, provision, and quality of the social services provided. He/she shall be responsible for, but not limited to, the following:

12.6.1 Implementing written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the social work service;

12.6.2 Participating in planning and budgeting for the social work service;

12.6.3 Coordinating and integrating the social work service with other patient care services;

12.6.4 Participating in staff committees;

12.6.5 Maintaining working relationships with administration through conferences, written memoranda, and other methods of exchanging information;

12.6.6 Assisting in the development of and participating in staff orientation and educational programs for the facility and the social work service, and documenting these activities;

12.6.7 Assessing each patient to identify any social needs or problems he/she may have in the facility and/or at home and/or with his/her family, reassessing the patient's social service needs in accordance with a schedule

which the social worker justifies and documents in the patient's medical record, and preparing an individual social service care plan if the assessment or reassessment indicates a need for social services;

12.6.8 Providing ongoing individual and/or group counseling of patients and their families, and writing clinical and progress notes;

12.6.9 Obtaining social services as specified in the social service care plan;

12.6.10 Contacting social and other agencies for information, referrals, and services; and

12.6.11 Participating in developing, reviewing, and revising the social service portion of patient care plans and discharge plans.

12.7 The social worker or designee shall enter in the patient's medical record:

12.7.1 A social service assessment initiated prior to or upon admission, after an initial interview with the patient and/or his/her family. This shall include a social history, including family background, education, employment, interests, activities, organizational memberships, psychosocial functioning, relationships with family and friends, and reason for, and reactions to, participation in the program. The assessment shall be reviewed and revised in accordance with a schedule justified and documented by the social worker in the patient's medical record;

12.7.2 The social service care plan, if the initial or subsequent assessment indicates a need for social services. This shall be reviewed and revised as necessary in accordance with a schedule justified and documented in the patient's medical record;

12.7.3 Clinical notes, if counseling is provided;

12.7.4 Progress notes if the patient is receiving social services. These shall be written in accordance with a schedule justified and documented in the patient's medical record;

12.7.5 All referrals to outside resources and documentation of follow-up; and

12.7.6 The social service portion of the discharge summary and discharge plan.

12.8 The social worker or designee may file information relating to the patient apart from the patient's medical record, with an entry in the record indicating the availability of the additional material upon the social worker's or designee's approval.

12.8.1 The facility shall establish written policies and procedures concerning the types of information which may be filed apart from the patient's medical record.

## 13.0 Patient Activities Services

13.1 The facility shall provide a planned, diversified program of patient activities designed to stimulate and support the use of the patient's physical and mental capabilities to the fullest extent and to enable him/her to maintain a sense of usefulness and self-respect.

13.2 The facility shall maintain the organization, management, and operation of patient activities services in accordance with a written organizational plan which shall describe the responsibility, authority, and accountability relationships of personnel, the functional structure of the service, and the relationship of the patient activities service to other services.

13.3 The facility shall ensure that:

13.3.1 A planned schedule of diverse physical, social, intellectual, spiritual, cultural, and recreational activities consisting of individual, group, and independent activities is available during the facility's hours of operation;

13.3.2 Patients 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 in the patient's medical record;

13.3.3 Indoor and outdoor recreation is provided;

13.3.4 Methods of transportation are provided for patients to and from destinations in the community in order to participate in patient activities programs; and

13.3.5 Provisions are made for the establishment of a Patient Council made up of patients of the facility.

13.4 The facility shall appoint a patient activities coordinator who shall provide patient activities services in the facility at least ten hours per week for every 15 patients.

13.5 If the patient activities coordinator does not meet the requirements in 1.52 a patient

activities consultant shall be appointed. He/she shall provide at least four hours of consultation in the facility per month until the activities coordinator meets the requirements, a period not to exceed two years.

13.6 The patient activities coordinator shall be responsible for the direction and quality of the patient activities provided. He/she shall be responsible for, but not limited to, the following:

13.6.1 Developing and maintaining written objectives, standards of practice, policies, a procedure manual, and an organizational plan for the patient activities service;

13.6.2 Participating in planning and budgeting for the patient activities service, including recommending to the administrator the number and levels of patient activities personnel to be employed and the equipment and supplies to be purchased;

13.6.3 Coordinating and integrating the patient activities service with other patient care services in the facility and with services in the community;

13.6.4 Participating in staff committees;

13.6.5 Maintaining working relationships with administration through conferences, written memoranda, and other methods of exchanging information;

13.6.6 Developing and maintaining written job descriptions for patient activities personnel;

13.6.7 Assisting in selecting for employment, assigning duties to, supervising, and evaluating all patient activities personnel;

13.6.8 Assisting in the development of and participating in staff orientation and educational programs for the facility and the patient activities service, and documenting these activities;

13.6.9 Maintaining a current record of community services, resources, programs, and materials, accessible to staff and to patients;

13.6.10 Developing a written monthly activities schedule at least one month in advance;

13.6.11 Conspicuously posting the current monthly activities schedule;

13.6.12 Ascertaining from the attending physician's medical orders those patients who are able to participate in the activities program and any limitations to their participation;

13.6.13 Assessing the activities needs of each patient prior to admission, preparing an individual patient activities care plan, and reassessing the patient's response to patient activities in accordance with a schedule justified and documented in the patient's medical record, after reviewing with the patient his/her participation in the activities program;

13.6.14 Providing patient activities guidance and consultation to other patient care personnel;

13.6.15 Organizing and meeting with a Patient Activities Committee of patients to develop activity programs; and

13.6.16 Participating in developing, reviewing, and revising the patient activities portion of patient care plans and discharge plans.

13.7 The patient activities coordinator shall enter in the patient's medical record:

13.7.1 The patient activities care plan. This shall be reviewed by the patient activities coordinator and revised as necessary in accordance with a schedule justified and documented in the patient's medical record by the patient activities consultant, if the coordinator does not meet the requirements in 1.52;

13.7.2 Progress notes, written in accordance with a schedule justified and documented in the patient's medical record after reviewing with the patient his/her participation and progress in patient activities; and

13.7.3 The patient activities portion of the discharge summary and discharge plan.

## 14.0 Dental Services

14.1 The facility shall make available dental services, either directly or through written agreement, including, but not limited to, examinations, oral prophylaxis, and emergency dental care to relieve pain and infection.

14.2 The facility shall appoint a consultant or staff dentist who shall be responsible for, but not limited to, the following:

14.2.1 Developing and implementing written dental service and oral hygiene policies and procedures for the care of patients; and

14.2.2 Providing staff education for nursing and other personnel in implementing the dental service and oral hygiene policies and procedures.

14.3 The facility shall ensure that arrangements are made for transportation for dental services and emergency dental services.

14.4 The consultant or dental provider shall document all dental services rendered in the patient's medical record.

## 15.0 Laboratory, Radiological, and Diagnostic Services

15.1 The facility shall make available laboratory, radiological, and diagnostic services directly, or through written agreement with facilities licensed or approved by the Department to provide such services.

15.2 The facility shall establish written policies to ensure that patients receive laboratory, radiological, and diagnostic services as ordered by a physician.

15.3 If a facility provides inpatient laboratory, radiological, and diagnostic services, it shall comply with all federal and state laws regulating these services.

15.4 Findings of such services shall be reported in writing to the physician ordering the service.

15.5 The facility shall arrange transportation to and from the service.

15.6 Signed and dated reports of laboratory, radiological, and diagnostic services shall be entered in the patient's medical record.

## 16.0 Patient Rights

16.1 The facility shall establish written policies regarding the rights and responsibilities of patients and shall be responsible for developing and adhering to procedures implementing such policies. These policies and procedures shall be available to patients, the public, and to each member of the facility's staff. They shall be posted in a public place in the facility.

16.2 The staff of the facility shall be trained to implement these policies and procedures, as specified in the staff education plan.

16.3 The facility shall comply with the standards in this document and with all applicable state and federal statutes, rules, and regulations concerning patient rights.

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

16.4.1 Is informed of these rights, as evidenced by his/her written acknowledgment prior to or at the time of admission and during stay, and is given a statement of the facility's rules and regulations and an explanation of the patient's responsibility to obey all regulations of the facility and to respect the personal rights and private property of other patients;

16.4.2 Is informed, and is given a written statement prior to or at the time of admission and during stay, of services available in the facility and of related charges, including any charges for services not covered by sources of third party payments or not covered by the facility's basic per diem rate. This statement shall include the payment, fee, deposit, and refund policy of the facility;

16.4.3 Is allowed to retain the services of his/her personal physician at his/her own expense or under a health care plan; is assured of medical care; is afforded the opportunity to participate in the planning of his/her care and treatment; is permitted to refuse medication and treatment after being informed of and understanding the consequences of such actions, and

to refuse to participate in experimental research (but if he/she chooses to participate, his/her informed written consent shall be obtained);

16.4.4 Is free from mental and physical abuse, and free from chemical and physical restraints. Drugs and other medications shall not be used for punishment, for convenience of facility personnel, or in quantities that interfere with a patient's rehabilitation or living activities;

16.4.5 Is assured confidential treatment of his/her personal and medical records, and shall approve or refuse their release to any individual outside the facility, except in the case of the patient's transfer to another health care institution, or as required by law or third party payment contract;

16.4.6 Is treated with consideration, respect, and full recognition of his/her dignity, individuality, and right to privacy, including, but not limited to, privacy concerning his/her treatment and condition and the care of his/her personal needs. Privacy of the patient's body shall be maintained during, but not be limited to, toileting, bathing, and other activities of personal hygiene, except as needed for patient safety or assistance;

16.4.7 Is not required to perform services for the facility;

16.4.8 Is permitted to associate and communicate privately with persons of his/her choice, join with other patients or individuals within or outside the facility to work for improvements in patient care, and, upon his/her request, shall be given assistance in the reading and writing of correspondence;

16.4.9 Is permitted to participate in facility activities, and meet with and participate in activities of social, religious, and community groups at his/her discretion;

16.4.10 Is allowed unaccompanied access to a telephone in the facility;

16.4.11 Is assured of exercising 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. The facility shall encourage and assist in the exercise of these rights;

16.4.12 Is not the object of discrimination with respect to participation in activities including, but not limited to, recreation, meals, or other social functions because of age, race, religion, sex, or nationality;

16.4.13 Is not deprived of any constitutional, civil, and/or legal right solely by reason of admission to the facility; and

16.4.14 Is allowed to discharge him/herself from the facility upon presentation of a written release and, if the patient is an adjudicated mental incompetent, upon the written consent of his/her next of kin and/or sponsor and/or guardian.

## 17.0 Continuity of Patient Care

17.1 The facility shall provide for continuity of patient care while the patient is receiving medical day care services.

17.2 Written policies and procedures shall be implemented ensuring that:

17.2.1 A system of patient registration is established whereby a patient is enrolled in a program of care. Registration will initiate a scheduling and alerting system to ensure that all necessary appointments and follow-up visits for health services take place. The dignity and personal privacy of the patient shall not be infringed upon by the registration system;

17.2.2 A system is established whereby, whenever possible, the patient is cared for by the same health professional;

17.2.3 Results of all consultations, including telephone consultation and referrals both within the facility and with other health and health-related agencies, are available in the patient's record prior to the patient's next scheduled visit to the facility; and

17.2.4 Printed or written instructions, including multilingual instructions as indicated, shall be available to the patient in addition to verbal instruction provided by staff.

17.3 The facility shall establish and implement a discharge planning program to ensure continuity of patient care.

17.3.1 The administrator in conjunction with the multidisciplinary team shall develop written discharge planning objectives, policies, and procedures, approved by the Department, which shall describe:

17.3.1.1 The functions of the person or persons responsible for discharge planning and his/her/their authority;

17.3.1.2 The time period, not to exceed 14 days following admission, in which each patient's needs for discharge planning are determined. The

patient's attending physician shall indicate in the patient's medical record anticipated length of stay and potential discharge problems;

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

17.3.1.4 The manner in which the facility shall utilize the multidisciplinary team approach in discharge planning; and

17.3.1.5 The methods used to involve the patient and his/her family and/or guardian in discharge planning.

17.3.2 A member of the multidisciplinary team designated by the administrator shall develop, implement, and maintain the discharge planning program. He/she shall be responsible for, but not limited to, performing and documenting the following:

17.3.2.1 Reviewing each patient's medical record, evaluating each patient's discharge planning needs, and developing discharge planning goals for each patient;

17.3.2.2 Developing the patient's discharge plan, in collaboration with the multidisciplinary team and other personnel involved in the patient's care;

17.3.2.3 Making referrals to agencies involved in follow-up care;

17.3.2.4 Coordinating services within the facility and with outside agencies to ensure continuity of care; and

17.3.2.5 Developing a staff educational program on discharge planning which shall include, but not be limited to, orientation of each new employee involved in patient care to the objectives and functions of discharge planning and to the role of the staff in discharge planning.

17.3.3 Education and involvement of the patient and his/her family and/or guardian in discharge planning shall be directed toward:

17.3.3.1 Understanding illness, disability, and needed treatment;

17.3.3.2 Management of finances, if requested by the patient or his/her family and/or guardian; and

17.3.3.3 Implementation of self-care and treatment measures following discharge.

17.3.4 The discharge summary and discharge plan shall incorporate the discharge summaries and discharge plans for each service that the patient receives.

17.3.5 The multidisciplinary team shall annually evaluate in writing the discharge planning program. The evaluation shall describe the effect of the program upon patients, personnel, the facility, and costs, and the status of the program in meeting discharge planning objectives.

17.3.5.1 Evaluation shall be performed both retrospectively (assessment of patients who have been discharged) and concurrently (assessment of patients currently in the facility).

## 18.0 Medical Records

18.1 The facility shall maintain a complete medical record for each patient, filed in the nursing area where the patient is located, and containing documentation of all services provided.

18.2 The facility shall assign supervisory responsibility for the medical record service to a full-time employee who, if not a medical record practitioner, functions with consultation from a person so qualified.

18.3 The complete medical record shall include, but not be limited to, the following:

18.3.1 Patient identification data, including name, date of admission, address, telephone number, date of birth, race and religion (optional), sex, referral source, financial identification, name, address, and telephone number of person to be notified in an emergency, and travel directions to the patient's home;

18.3.2 Names of the patient's attending physician and designated alternate(s);

18.3.3 The patient's signed acknowledgement that he/she has been informed of patient rights. This may be included at the time of discharge;

18.3.4 A physician's signed and dated admission history, report of physical examination, medical care plan, and written documentation as required in standards 7.7.2 through 7.7.2.3;

18.3.5 Number of days patient is scheduled for attendance and method of transportation;

18.3.6 An assessment of the patient's home environment based on a home visit;

18.3.7 An assessment of the patient by the multidisciplinary team;

18.3.8 Daily records of patients' attendance and of services utilized, including transportation;

18.3.9 All initial and subsequent orders by a physician, including frequency and modality of services provided;

18.3.10 A record of physician visits;

18.3.11 A patient care plan. This may be included at the time of discharge;

18.3.12 A care plan for each service providing care to the patient;

18.3.13 A social service assessment;

18.3.14 Clinical notes;

18.3.15 Progress notes;

18.3.16 A pharmacist consultation sheet;

18.3.17 A record of medications administered including the name and strength of the drug, date and time of administration, dosage administered, route of administration and signature of the licensed nurse administering the drug. (Initials may be used after the licensed nurse's signature appears at least once on each page of the documentation.) In the event of self-administration, a record based on the facility's policy and procedures shall be included;

18.3.18 Reports of laboratory, radiological, and diagnostic services;

18.3.19 Documentation of accidents and incidents;

18.3.20 A record of any treatment, medication, or service refused by the patient, including visits to a physician;

18.3.21 Records of dental care provided;

18.3.22 Summaries of services provided at other health and health-related facilities;

18.3.23 Reports of podiatric services, eye examinations, and audiologic evaluation;

18.3.24 Summaries of conferences and consultations; and

18.3.25 A discharge summary and discharge plan.

18.4 A unit record system shall be maintained, in which the patient's complete medical record is filed as one unit.

18.5 All orders for treatment, medication, and/or therapeutic diets shall be written, dated, and signed by the physician. All entries, including progress notes, contained in the patient's medical record shall be typewritten or written in ink, legible, and dated and signed by the recording person.

18.6 All medical records shall be preserved in accordance with N.J.S.A. 26:8-5 et seq.

18.7 Upon transfer of a patient to another health care facility, a copy, summary, or abstract of the patient's medical record shall be sent to the receiving facility with the written consent of the patient or his/her next of kin and/or sponsor and/or guardian. In the event of denial of permission, a copy of the written denial shall be kept in the patient's medical record at the facility. If the patient, next of kin, sponsor, or guardian refuses to sign the denial of permission, a witnessed written statement by a staff member to that effect shall be included in the patient's medical record.

18.8 The medical record of a discharged patient shall be completed and signed within 30 days of discharge.

18.9 If the facility ceases to operate, it shall notify the Department in writing at least 14 days before cessation of operation, regarding how and where medical records shall be stored.

18.10 The facility shall develop and implement written policies and procedures, approved by the Department, governing the availability, release, and/or provision of copies of the medical record to patients and/or the patient's authorized representative.

18.10.1 The written policies and procedures shall include, but not be limited to, the following:

18.10.1.1 A description of the procedures to protect medical record information against loss, destruction, or unauthorized use;

18.10.1.2 A schedule of fees, as established by the facility, for obtaining copies of the medical record;

18.10.1.3 The business hours, as defined by the facility, during which the patient has access to his/her medical records; and

18.10.1.4 In the event that it is medically contraindicated (as documented by a physician in the patient's medical record) that the patient have access to or obtain copies of his/her medical record, the medical record shall be made available to the patient's authorized representative.

18.10.2 The facility shall ensure that a patient's medical record is provided within at least 30 calendar days of the written request.

18.10.3 The medical record shall mean in this instance all records in the facility which pertain to the patient including X-ray films.

## 19.0 Patient Care Statistics

19.1 The facility shall maintain the following written records in a place, form, and system approved by the Department:

19.1.1 An admission/discharge register consisting of a daily chronological listing of patients admitted and discharged, including name of patient, age, sex, date of birth, diagnosis, place from which patient is admitted or transferred (for admissions), and place to which patient is discharged or transferred (for discharges); and

19.1.2 A daily total of patients attending the facility.

19.2 The medical day care facility shall maintain and provide statistical data as required by the Department. The data shall be reported on a quarterly basis on forms supplied by the Department.

## 20.0 Financial Data

20.1 Upon development of a uniform cost reporting system approved by the Health Care Administration Board, the facility shall adopt and maintain that system, from which reports will be prepared to meet the requirements of the Commissioner, as stated in Chapter 136, P.L. 1971, Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq.

20.2 An annual financial report shall be submitted to the Department and shall include a statement of income and expenditure by unit of service.

## 21.0 Housekeeping Services

21.1 The facility shall maintain the organization, management, and operation of housekeeping services in accordance with a written organizational plan which shall describe the responsibility, authority, and accountability relationships of personnel, the functional structure of the service, and the relationship of the housekeeping service to other services.

21.2 The administrator or his/her designee shall ensure that:

21.2.1 A written work plan for cleaning operations is developed, with categorization as to daily, weekly, monthly, or annual assignment for each area of the facility;

21.2.2 All housekeeping personnel are assigned duties, supervised, and evaluated;

21.2.3 Housekeeping personnel are trained in procedures of cleaning, including the use, cleaning, and care of equipment;

21.2.4 Procedures are developed for selection and use of housekeeping and cleaning products and equipment; and

21.2.5 Housekeeping services are evaluated.

21.3 The facility shall comply with the provisions of the New Jersey State Sanitary Code and with the following:

21.3.1 The facility and its contents shall be free from dust, dirt, and debris;

21.3.2 Nonskid wax shall be used on all waxed floors;

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

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

21.3.5 All mechanical equipment shall be in working order, covered to protect from contamination, and accessible for cleaning and inspection;

21.3.6 All equipment shall have unobstructed space provided for operation;

21.3.7 All equipment and materials necessary for cleaning, disinfection, and sterilization shall be provided;

21.3.8 Thermometers shall be maintained in refrigerators and storerooms used for perishable items;

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

21.3.10 Pesticides shall be applied so as to prevent contamination to patients and food. Vapona (insecticidal) strips shall not be used anywhere in the facility;

21.3.11 Articles in storage shall be elevated from the floor to facilitate cleaning and eliminate rodent harborages;

21.3.12 Unobstructed aisles shall be provided between articles in storage;

21.3.13 A program shall be maintained to keep rodents, insects, vermin, birds, animals, dust, and contamination out of the facility;

21.3.14 Insect and rodent harborages shall be eliminated from the facility;

21.3.15 Toilet tissue shall be provided at each toilet at all times;

21.3.16 Solid or liquid waste, garbage, and trash shall be disposed of or stored in a manner approved by the Department and so as to prevent fire, contamination, or transmission of disease. Solid waste shall be stored in insect- and rodent-proof, fireproof, nonabsorbent, watertight containers with tightfitting covers;

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

21.3.18 All patient areas shall be free from noxious odors.

21.4 If a commercial housekeeping service is used, it shall be required to maintain at least the standards outlined herein.

21.5 Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing, and handwashing facilities shall not exceed 110 degrees F (43 degrees C).

21.6 The administrator or his/her designee shall ensure that:

21.6.1 Written policies and procedures for linen and laundry services, including methods of storage and transportation, are developed and implemented;

21.6.2 The reserve supply of sheets, pillowcases, and blankets is at least ten percent of the amount used per week;

21.6.3 Soiled linen and laundry are collected so as to avoid microbial dissemination into the environment, and are placed 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 soiled linen and laundry; and

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

## 22.0 Evaluation

22.1 A written plan for audit and evaluation of patient care shall be developed annually by the facility and submitted, upon request, to the Department for approval. The plan shall specify the personnel to be involved in the evaluation process and the schedule for evaluation proceedings, and shall provide for ongoing monitoring of staff and program activities and for audit of patient medical records.

22.2 A multidisciplinary Evaluation Committee shall be appointed by, and shall be accountable to, the governing authority. The Committee shall be responsible for, but not limited to, the following:

22.2.1 Annual review of staff qualifications;

22.2.2 Evaluation of the effect on the facility of policies, procedures, and administrative practices;

22.2.3 Annual review of patient care statistics;

22.2.4 Annual review of staff orientation and educational programs;

22.2.5 Evaluation of the processes by which care and services are delivered to patients, staffing patterns, maintenance of physical plant and equipment, and reports of infection control; and

22.2.6 Audit of patient medical records on an ongoing basis by means of:

22.2.6.1 Establishment of objective criteria for evaluating each service providing patient care;

22.2.6.2 Review of patient medical records for their conformity to established criteria; and

22.2.6.3 Recording of deficiencies found.

22.3 The Evaluation Committee shall prepare at least an annual written report of its findings, including recommendations for corrections or improvements, which shall be submitted to the governing authority.

22.4 The administrator shall, with the approval of the governing authority, implement measures to ensure that corrections or improvements are made.

## 23.0 Infection Control

23.1 The facility shall establish a multidisciplinary Infection Control Committee, consisting of at least the medical director, the administrator, and a licensed nurse who represents the nursing service. A representative of each service offered by the facility shall serve on the Committee at least on a consultative basis.

23.2 The Committee shall be responsible for, but not limited to, the following:

23.2.1 In conformance with the New Jersey State Sanitary Code, development and implementation of a system for investigating, reporting, evaluating, and maintaining records for patients and personnel of infections which are reportable, or which may be related to activities and procedures of the facility, as a means of surveillance and monitoring of the effectiveness of infection control measures; and

23.2.2 Development of written policies and procedures, approved by the Department, for cleaning, disinfection, and sterilization practices and techniques used in the facility, including, but not limited to, the following:

23.2.2.1 Care of utensils, instruments, solutions, dressings, articles, and surfaces;

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

23.2.2.3 Procedures for care of equipment and other devices that provide a portal of entry for pathogenic microorganisms;

23.2.2.4 Selection, storage, use, and disposition of nondisposable patient care items;

23.2.2.5 Selection, storage, use, and disposition of disposable patient care items. Disposable items shall not be reused; and

23.2.2.6 Selection, storage, use, and disposition of hypodermic needles and syringes, in accordance with N.J.S.A. 2A:170-25.17.

23.3 Each service in the facility shall develop written infection control policies and procedures for that service, based upon those developed by the Infection Control Committee.

23.4 The occurrence of a reportable disease shall be reported in conformance with Chapter 2 of the New Jersey State Sanitary Code (N.J.S.A. 26:1A-7 et seq. and N.J.A.C. 8:57-1 et seq.). The facility shall also have written policies and procedures, developed by the Infection Control Committee, for reporting other diseases according to Regulations 2 and 3 of Chapter 2. The Infection Control Committee shall develop policies and procedures for exclusion from work, and authorization to return to work, of employees with communicable diseases.

23.5 Written reports of state and local sanitary inspections, including cultures taken on food, equipment, and personnel, shall be available to the Infection Control Committee for evaluation and corrective action in accordance with Chapter 2 of the New Jersey State Sanitary Code (N.J.S.A. 26:1A-7 et seq. and N.J.A.C. 8:57-1 et seq.) and with Chapter 12 of the New Jersey State Sanitary Code (N.J.S.A. 24:15-1 et seq. and N.J.A.C. 8:24-1 et seq.).

## 24.0 Emergency Procedures (Including Equipment Breakdown, Disaster, and Fire Plan)

24.1 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. The plan shall be developed with the assistance of fire and safety experts from local municipalities.

24.2 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.

24.3 Simulated drills of all plans shall be conducted on each shift at least four times a year and a record written of each such drill, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The drills shall include at least these types of emergencies:

24.3.1 Medical emergency;

24.3.2 Equipment failure or power loss;

24.3.3 Fire; and

24.3.4 Other disaster (storm, flood, other natural disaster, bomb scare, or military alert).

24.4 The facility shall test at least one manual pull alarm each week of the year, and maintain a written log showing test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition.

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

24.6 All plans shall be posted throughout the facility.

24.7 The facility shall provide emergency medical services on the premises during the hours of operation. Services that cannot be provided at the facility shall be provided through

contractual arrangement with a backup hospital. Information regarding availability of emergency services at a hospital during the hours the facility is not in operation shall be provided to all patients.

24.7.1 The facility shall maintain in the nurses' area emergency equipment and an emergency medication kit approved by the Pharmaceutical Services Committee and the Department.

## 25.0 Construction

25.1 New construction and alterations, renovations, and additions in freestanding medical day care centers shall comply with the State of New Jersey Uniform Construction Code, Chapter 23, Title 5, New Jersey Administrative Code, Use Group Business (B).

25.2 New construction and alterations, renovations, and additions in long-term care facilities for medical day care centers shall comply with the State of New Jersey Uniform Construction Code, Chapter 23, Title 5, New Jersey Administrative Code, Use Group I-2 (Institutional).

25.3 All medical day care facilities shall be constructed in such a manner as to be accessible to the physically handicapped, including patients, staff, and members of the public.

25.4 Design Standards in all medical day care facilities shall conform with the Technical Handbook for Facilities Engineering and Construction Manual, OFEPM/DHEW Handbook, Part 4, Series 4.12, Design of Barrier-free Facilities, dated August 1978.

## 26.0 Additional Requirements

26.1 Facilities shall conform with the following sections of HRA 79-14500, Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities[1]:

26.1.1 Section 9.1A - Narrative Program;

26.1.2 Section 9.1H - Parking;*

26.1.3 Section 9.2 - Administration and Public Areas;*

26.1.4 Section 9.3 - Clinical Facilities;

26.1.4.1 Section A. General Purpose Examination Room(s);

Section E. Facilities for Charting and for Clinical Records or Nurses' Area(s). (A and E may be combined);

Section G. Clean Workroom or Clean Holding Room;*

Section H. Soiled Workroom or Soiled Holding Room;*

26.1.5 Section 9.5 - Janitor's Closets - One janitor closet per floor;

26.1.6 Section 9.6 - Employees' Facilities;*

26.1.7 Section 9.7 - Engineering Service and Equipment Areas;*

26.1.8 Section 9.8 - Details and Finishes;

26.1.9 Section 9.9 - Construction, Including Fire-resistive Requirements;

26.1.10 Section 9.10 - Elevators - Covered under the Federal Barrier-free Standards Code;*

26.1.11 Section 9.12G - Emergency Lighting - Emergency lighting shall be provided;

26.1.12 Section 8.7A - Dietary Facilities;*

26.1.13 Section 10.8B - Dietary Services;

26.1.14 Rehabilitation Services;

26.1.14.1 Section 10.10 - Personal Care Unit for patients, if required by program;*

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[1] HEW Publication No. HRA 79-14500 may be obtained from the U.S. Government Printing Office, Washington, D.C., at a cost of $3.00.

26.1.14.2 Section 10.19 - Physical Therapy Unit, if required by program;* and

26.1.14.3 Section 10.20 - Occupational Therapy Unit, if required by program.*

26.2 Services

26.2.1 Toilet Facilities - There shall be one water closet and lavatory for every eight patients.

26.2.2 One chaise lounge, bed, or reclining chair per ten patients shall be provided.

26.2.3 There shall be a Patient Activities area.

* May be shared with existing facilities in a long-term care facility

## 27.0 Rescinding Former Regulations

27.1 These regulations shall rescind all previous standards for day care services.