CHAPTER 100

OFFICE OF THE OMBUDSMAN FOR THE INSTITUTIONALIZED ELDERLY PRACTICE AND PROCEDURE RULES

Authority

N.J.S.A. 52:27G–1 et seq.

Source and Effective Date

R.1990 d.316, effective June 18, 1990.
See: 22 N.J.R. 1016(c), 22 N.J.R. 1926(a).

Executive Order No. 66(1978) Expiration Date

Chapter 100, Office of the Ombudsman for the Institutionalized Elderly Practice and Procedure Rules, expires June 18, 1995.

Historical Note

Chapter 100, Ombudsman Practice and Procedure and Public Notice Requirements, was filed on April 30, 1979 and became effective on May 1, 1979 as R.1979 d.166. See: 11 N.J.R. 164(b), 11 N.J.R. 274(a). Further amendments were filed and became effective on September 28, 1979 as R.1979 d.386. See: 11 N.J.R. 431(a), 11 N.J.R. 536(a). Pursuant to Executive Order No. 66(1978), Chapter 100 was readopted as R.1989 d.295. See: 21 N.J.R. 368(a), 21 N.J.R. 1516(b).

Prior rulemaking activity in Chapter 100, Ombudsman Practice and Procedure and Public Notice Requirements, repealed by R.1990 d.316, effective June 18, 1990.

Cross References

Blind and visually impaired services institutional abuse of elderly persons reporting; see N.J.A.C. 10:91–5.10.

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SUBCHAPTER 1. GENERAL PROVISIONS

Historical Note

Further amendments were filed and became effective on May 30, 1980 as R.1980 d.233. See: 12 N.J.R. 250(a), 12 N.J.R. 387(a). Further amendments were filed and became effective June 20, 1983 as R.1983 d.215. See: 15 N.J.R. 588(a), 15 N.J.R. 1016(a). Further amendments were filed and became effective May 7, 1984 as R.1984 d.168. See: 16 N.J.R. 476(a), 16 N.J.R. 1072(a).

5:100–1.1 Scope

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

5:100–1.2 Definitions

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

"Abuse" means the willful infliction of physical pain, injury or mental anguish; unreasonable confinement; or the willful deprivation of services which are necessary to maintain a resident's physical and mental health. "Abuse" shall also mean imposing treatment upon a resident who has the capacity to make healthcare decisions, after the resident has made a voluntary and informed choice regarding such treatment. "Abuse" shall also mean providing to a resident treatment that is not medically indicated. However, no resident shall be deemed to be abused for the sole reason that he or she is being furnished non-medical remedial treatment by spiritual means through prayer alone, in accordance with a recognized religious method of healing, in lieu of medical treatment, if it is shown through the Office's review that the resident subscribes to such religious method of healing. "Abuse" also shall not mean the withholding or withdrawal of life-sustaining treatment in accordance with the provisions of N.J.A.C. 5:100–2.

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

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

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

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

"Facility" means any facility or institution, whether public or private, offering health or health-related services for the institutionalized elderly, and which is subject to regulation, visitation, inspection, or supervision by any government agency. Facilities include, but are not limited to, nursing homes, skilled nursing homes, intermediate care facilities, extended care facilities, convalescent homes, rehabilitation centers, residential healthcare facilities, class "C" and "D" boarding homes, special hospitals, veterans' hospitals, chronic disease hospitals, psychiatric hospitals, mental hospitals, mental retardation centers or facilities, day care facilities for the elderly, and medical day care centers. "Facility" shall not mean an acute care hospital.

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

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

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

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

"Resident" means any elderly person who is receiving treatment or care in any facility in all its aspects, including, but not limited to, admission, retention, confinement, commitment, period of residence, transfer, discharge and any instances directly related to such status. "Resident" shall also mean a patient or client who is receiving treatment or care in any facility.

Case Notes

Ombudsman's regulation defining "abuse" as "providing to a resident treatment that is not medically indicated" was reasonable. Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

Ombudsman's regulation defining "abuse" as "imposing treatment upon a resident who has the capacity to make health care decisions, after a resident has made a voluntary and informed choice regarding such treatment" conformed with Supreme Court guidelines. Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

Ombudsman for Institutionalized Elderly erroneously substituted opinion of only attending physician for required opinions of "two non-attending physicians." Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

Ombudsman properly recognized that it is not abuse of institutionalized elderly patient when attending physician alone determines life-sustaining treatment is not medically indicated because patient's life is not at risk or is no longer at risk. Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

Ombudsman for Institutionalized Elderly could supplement statutory general definition of "abuse". Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

5:100–1.3 Contact with the Office; information about rights and entitlements; communications

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

(b) The Office may be contacted by calling its toll-free telephone number (800–624–4262), 24 hours per day, any day of the year; or by writing to: The Office of the Ombudsman for the Institutionalized Elderly, CN 808, Trenton, New Jersey, 08625–0808.

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

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

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

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

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

5:100–1.4 Complaint procedure

(a) The Office shall acknowledge all complaints. If the Office does not have jurisdiction, the Office shall so advise the person making the complaint and shall promptly refer the complaint to the appropriate government agency.

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

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

1. The complaint is trivial, frivolous, vexatious or not made in good faith;

2. The complaint has been too long delayed to justify present investigation;

3. The resources available, considering the Office's established priorities, are insufficient for an adequate investigation; or

4. The matter complained of is not within the investigatory authority of the Office.

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

1. Make the necessary inquiries and obtain such information as it deems necessary;

2. Hold private hearings or public hearings;

3. Enter without notice and, after notifying the person in charge of its presence, inspect the premises of a facility or government agency and inspect there any books, files, medical records or other records that pertain to residents, which are required by law to be maintained by the facility or government agency;

4. Compel at a specific time and place, by subpoena, the appearance and sworn testimony of any person who the Office reasonably believes may be able to give information relating to a matter under investigation; and

5. Compel any person to produce at a specific time and place, by subpoena, any documents, books, records, papers, objects, or other evidence which the Office reasonably believes may relate to a matter under investigation.

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

1. If Office representatives are unable to substantiate a complaint, the Office shall so advise the complainant and the facility or government agency against whom the complaint was brought, as appropriate;

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

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

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

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

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

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

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

(g) Where the Office has substantiated the allegations set forth in a complaint, it shall notify the complainant and the facility or government agency concerning which the com-

plaint was lodged, in writing, of its findings and action taken. Such notification to a facility or government agency concerning which a complaint was lodged shall not include the identity of the complainant, resident or witnesses, unless such persons authorize, in writing, such disclosure.

5:100–1.5 Reporting requirements and complaint procedures under the Mandatory Adult Abuse and Exploitation Reporting Law, N.J.S.A. 52:27G–7.1 et seq.

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

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

1. The name, address and age of the elderly person who is the subject of the suspected abuse or exploitation;

2. The name of the person accused of committing the alleged abuse or exploitation;

3. The name and address of the facility involved;

4. A description of the nature of the suspected abuse or exploitation;

5. The date, time and specific location of the occurrence;

6. The name and address of any witness to the suspected abuse or exploitation; and

7. Any other information which might be helpful in an investigation of the case and the protection of such elderly person.

(c) The Office complaint procedure is as follows:

1. Within 24 hours of receipt of a report of abuse or exploitation, the Office shall notify the Commissioner of Human Services and any other government agency which regulates or operates the facility.

2. Whenever practicable, upon receiving such report, the Office shall advise the Administrator of the facility in which the victim is residing, or his or her designee, of a report of abuse or exploitation. Unless authorized under (e) below, the name of the person reporting the suspected abuse or exploitation shall not be disclosed.

3. The Office shall investigate a complaint alleging elderly abuse or exploitation by utilizing the procedure set forth in N.J.A.C. 5:100–1.4. In addition, an investigation shall include a visit with the elderly person who has allegedly been abused or exploited and consultation with others who have knowledge of the particular case.

(d) Upon completing its investigation, the Office shall report its findings, in writing, to:

1. The person who reported the suspected abuse or exploitation;

2. The Commissioner of Human Services;

3. The facility in which the elderly person who was allegedly abused or exploited is residing. Such notification shall contain a general description of the Office's investigation and its findings, but shall not include the identity of the complainant, the victim or witnesses, unless such persons authorize, in writing, such disclosure;

4. Where the Office has substantiated the allegations of the complaint, and where appropriate, the county prosecutor's office or any other appropriate prosecuting agency; and

5. Where the Office has substantiated the allegations of the complaint, and where appropriate, the government agency or agencies having regulatory or licensing authority over either the person accused of the abuse or exploitation or over the facility in which the elderly person is residing.

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

1. The person who reported the abuse or exploitation specifically authorizes such disclosure; or

2. A judicial proceeding results from such report; or

3. Disclosure is authorized under N.J.A.C. 5:100–1.6(a).

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

(g) Pursuant to N.J.S.A. 52:27G–7.1(f), any person required to report suspected abuse or exploitation, as required herein, who fails to make the reports required by this section, may be fined up to $5,000. Such penalty will be collected and enforced by the Office in a summary proceeding brought pursuant to the Penalty Enforcement Law, N.J.S.A. 2A:58–1 et seq. Each violation of this section shall constitute a separate offense.

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

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

(j) Where the report alleging elderly abuse or exploitation pertains to the withholding or withdrawal of life-sustaining treatment from an elderly incompetent institutionalized resident, reporting shall be governed by N.J.A.C. 5:100–2.

5:100–1.6 Confidentiality of information; privileged communications

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

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

5:100–1.7 Prohibition of discriminatory, disciplinary or retaliatory action

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

5:100–1.8 Hindrance of Office or refusal to comply; penalties

Any person who willfully hinders the lawful actions of the Office or willfully refuses to comply with any of its lawful demands, including the demand of immediate entry into and inspection of a facility or government agency or the demand of immediate access to a resident thereof, may be fined up to $5,000. Such penalty shall be collected and enforced by the Office in a summary proceeding brought pursuant to the Penalty Enforcement Law, N.J.S.A. 2A:58–1 et seq., upon complaint of the Office or any other person. Each violation of this section shall constitute a separate offense.

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

5:100–2.1 Purpose

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

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

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

5:100–2.2 Definitions

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

"Capacity to make a healthcare decision" means the ability to understand and appreciate the nature and consequences of a healthcare decision, including the resident's diagnosis and prognosis, the benefits and risks associated with the decision and alternatives to the decision, and having the ability to voluntarily reason and make judgments about that information.

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

"Life-sustaining treatment" means any medical intervention that is administered to a resident in order to prolong life and delay death.

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

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

"Surrogate decisionmaker" means a guardian, a close and caring family member, or a person designated by the resident, who is willing and able to make a decision to withhold or to withdraw life-sustaining treatment on behalf of the resident.

Case Notes

It was error to substitute competency opinion of only attending physician for required opinions of "two non-attending physicians." Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

5:100–2.3 Duty to report

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

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

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

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

1. The resident is under age 60; or

2. The resident, being fully informed and having the capacity to make a health care decision, chooses to withhold or withdraw life-sustaining treatment. Two non-attending physicians shall make the determination of whether the resident is fully informed and has the capacity to make a health care decision. The physicians' determinations shall be based on the physicians' reasonable medical judgments and shall be documented on the resident's chart; or

3. The resident has a fully executed and valid Advance Directive ("Living Will") or Proxy Directive ("Durable Power of Attorney for Health Care"); or

4. The life-sustaining treatment is not medically indicated for the resident. The resident's attending physician shall make this determination. Such determination shall be based on the physician's reasonable medical judgment and shall be documented on the resident's chart; or

5. The proposal to withhold or withdraw life-sustaining treatment is being reviewed by, or has been reviewed favorably by, a court of competent jurisdiction.

Amended by R.1992 d.284, effective July 6, 1992.
See: 24 N.J.R. 1455(a), 24 N.J.R. 2431(a).
Advance or proxy directive provisions added at (d)3.

Case Notes

Office of Ombudsman for Institutionalized Elderly had authority to supplement statutory general definition of "abuse". Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

Regulation providing example of abuse of institutionalized elderly was reasonable. Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

Regulation giving example of abuse of institutionalized elderly conformed with Supreme Court guidelines. Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

Opinions of two non-attending physicians are required for determining whether institutionalized elderly person is competent to refuse life-sustaining treatment. Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

Regulation properly recognized that attending physician alone determine whether life-sustaining treatment is medically indicated. Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

5:100–2.4 Procedure for residents incapable of making healthcare decisions, who are in a persistent vegetative state

(a) Unless one or more of the circumstances set forth in N.J.A.C. 5:100–2.3(d) apply, the surrogate decisionmaker for the resident shall notify the Office, in writing, of a contemplated decision to withhold or to withdraw life-sustaining treatment from the resident.

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

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

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

1. Inquire into whether there exists any declaration or designation including an oral declaration or designation;

2. Interview the resident's family and friends, the attending physician, healthcare providers, employees of the facility at which the resident is residing, and others having knowledge of the resident's intent; and

3. Do anything that the Office, in its discretion, deems necessary to discover the resident's intent.

(e) Concurrent with its intent inquiry, the Office shall engage the services of two physicians who are not associated with the resident's case to examine the resident:

1. Prior to the examination, the Office shall provide to each physician, in writing, an explanation of the areas that must be covered in the report of the examination. The areas are:

i. The date(s) of the physician's examination(s) and the identity of anyone assisting or accompanying the physician;

ii. A synopsis of the physician's examination(s), the resident's medical history on which the physician bases his or her conclusions and any limitations on either, which the physician believes significant. The physician should also advise whether the medical history indicates whether the resident ever was competent during adult life;

iii. The resident's diagnosis and condition;

iv. The medical alternatives available including the various treatment options and the risks, side effects and benefits of each of those options;

v. The resident's prognosis for recovery, both with and without the life-sustaining treatment which has been proposed to now be withheld or withdrawn;

vi. Whether the resident is in a persistent vegetative state because there is no reasonable possibility of the resident's recovery to a cognitive, sapient state; and

vii. The likely outcome if treatment is discontinued or withheld.

2. The following areas shall also be addressed notwithstanding a determination that the resident is in a persistent vegetative state:

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

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

iii. The resident's present level of:

(1) Physical functioning;

(2) Sensory functioning;

(3) Emotional functioning; and

(4) Cognitive functioning;

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

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

vi. Whether the patient probably will regain competence.

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

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

5. Upon completing the examination, each physician shall provide to the Office a written report of the examination.

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

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

i. The resident's estate;

ii. The resident's family;

iii. The surrogate decisionmaker;

iv. Medicare or Medicaid; and/or

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

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

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

2. If there does not exist clear and convincing evidence regarding the resident's attitude toward life-sustaining treatment, the surrogate decisionmaker may withhold or withdraw the life-sustaining treatment if both physicians have also concluded that there is no reasonable possibility that the resident will recover to a cognitive,

sapient state. Additionally, the attending physician must concur with the conclusion of both independent physicians.

(g) When either of (f)1 or (f)2 above is satisfied, the Ombudsman shall defer to the surrogate decisionmaker's decision. A surrogate decisionmaker may seek a determination in a court of competent jurisdiction where the Ombudsman does not defer.

(h) When (f)2 above is satisfied, the resident's family member must also concur with the surrogate decisionmaker's decision, unless the family member is also the surrogate decisionmaker. "Family member" shall mean, in order of priority, the resident's spouse, parents, children, or next of kin, if any. A surrogate decisionmaker may seek a determination in a court of competent jurisdiction where the resident's family member does not concur.

(i) In the absence of bad faith, no participant in the decisionmaking process shall be civilly or criminally liable.

Amended by R.1992 d.284, effective July 6, 1992.
See: 24 N.J.R. 1455(a), 24 N.J.R. 2431(a).
Text at (d)1 deleted; text recodified.

Case Notes

Opinions of two non-attending physicians are required for determining whether institutionalized elderly person is competent to refuse life-sustaining treatment. Gleason v. Abrams, 250 N.J.Super. 265, 593 A.2d 1232 (A.D.1991).

5:100–2.5 Procedure for residents incapable of making healthcare decisions, who are not in a persistent vegetative state

(a) Unless one or more of the circumstances set forth in N.J.A.C. 5:100–2.3(d) apply, the surrogate decisionmaker for the resident shall notify the Office, in writing, of a contemplated decision to withhold or to withdraw life-sustaining treatment from the resident.

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

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

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

1. Inquire into whether there exists any declaration or designation including an oral declaration or designation;

2. Interview family and friends, the attending physician, healthcare providers, employees of the facility at which the resident is residing, and others with knowledge of the resident's intent; and

3. Do anything that the Office, in its discretion, deems is necessary to discover the resident's intent.

(e) Concurrent with its intent inquiry, the Office shall engage the services of two physicians who are not associated with the resident's case to examine the resident.

1. Prior to the examinations, the Office shall provide to each physician, in writing, an explanation of the areas that must be covered in the report of the examination. The areas are:

i. The date of the physician's examination(s) and the identity of anyone assisting or accompanying the physician;

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

iii. A synopsis of the physician's examination(s), the resident's medical history on which the physician bases his or her conclusions and any limitations on either, which the physician believes significant. The physician should also advise whether the medical history indicates whether the resident ever was competent during adult life;

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

v. The resident's present level of:

(1) Physical functioning;

(2) Sensory functioning;

(3) Emotional functioning; and

(4) Cognitive functioning;

vi. The resident's diagnosis and condition;

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

viii. The medical alternatives available including the various treatment options and the risks, side effects and benefits of each of those options;

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

x. The resident's prognosis for recovery, both with and without the life-sustaining treatment which has been proposed to now be withheld or withdrawn;

xi. Whether the patient probably will regain competence; and

xii. The likely outcome if treatment is discontinued or withheld.

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

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

4. Upon completing the examination, each physician shall provide to the Office a written report of the examination.

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

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

i. The resident's estate;

ii. The resident's family;

iii. The surrogate decisionmaker;

iv. Medicare or Medicaid; and/or

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

(f) Upon completion of the intent inquiry and if both physicians find that: the resident is incapable of making a healthcare decision, the resident is suffering from severe and permanent mental and physical impairments, and the resident probably would have less than one year to live from the date of the examination with or without life-sustaining treatment, the surrogate decisionmaker, with the concurrence of the attending physician, may withhold or withdraw the life-sustaining treatment if:

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

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

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

(g) When (f)1, f(2) or f(3) above is satisfied, the Ombudsman shall defer to the decision made by the surrogate decisionmaker. The surrogate decisionmaker may seek a determination in a court of competent jurisdiction where the Ombudsman does not defer.

(h) When either of f(2) or f(3) above is satisfied, the resident's family member must also concur with the decision made by the surrogate decisionmaker, unless the family member is also the surrogate decisionmaker. "Family member" shall mean, in order of priority, the resident's spouse, parents, children, or next of kin, if any. The surrogate decisionmaker may seek a determination in a court of competent jurisdiction where the resident's family member does not concur.

(i) In the absence of bad faith, no participant in the decisionmaking process shall be civilly or criminally liable.

Amended by R.1992 d.284, effective July 6, 1992.
See: 24 N.J.R. 1455(a), 24 N.J.R. 2431(a).
Text at (d)1 deleted; text recodified.