CHAPTER 39

STANDARDS FOR LICENSURE OF LONG-TERM CARE FACILITIES

Authority

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

Source and Effective Date

R.1994 d.582, effective November 21, 1994 (operative January 1, 1995, except Subchapter 43, which was operative November 21, 1994).
See: 26 N.J.R. 1772(c), 26 N.J.R. 4641(a).

Executive Order No. 66(1978) Expiration Date

Chapter 39, Standards for Licensure of Long-Term Care Facilities, expires on November 21, 1999.

Chapter Historical Note

Chapter 39, Standards for Licensure of Long-Term Care Facilities, was adopted as R.1977 d.222, effective January 1, 1978. See: 9 N.J.R. 171(c), 9 N.J.R. 322(c). The existing text of Chapter 39 was repealed and new rules regarding Long-Term Care Facilities were adopted as R.1983 d.236, effective June 20, 1983. See: 15 N.J.R. 279(a), 15 N.J.R. 1022(b). Chapter 39 was repealed and a new Chapter 39, Manual of Standards for Long-Term Care, was adopted as R.1988 d.280, effective June 20, 1988. See: 20 N.J.R. 469(a), 20 N.J.R. 1432(a). Pursuant to Executive Order No. 66(1978), Chapter 39 was readopted as R.1993 d.341, effective June 14, 1993. See: 25 N.J.R. 1474(a), 25 N.J.R. 2878(a).

Chapter 39 was repealed and a new Chapter 39, Standards for Licensure of Long-Term Care Facilities, was adopted as R.1994 d.582. See: Source and Effective Date.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. GENERAL PROVISIONS

8:39-1.1 Scope and purpose
8:39-1.2 Definitions

SUBCHAPTER 2. LICENSURE PROCEDURE

8:39-2.1 Certificate of Need
8:39-2.2 Application for licensure
8:39-2.3 Newly constructed or expanded facilities
8:39-2.4 Surveys and temporary license
8:39-2.5 Full license
8:39-2.6 Surrender of license
8:39-2.7 Waiver
8:39-2.8 Action against licensee
8:39-2.9 Special long-term care services
8:39-2.10 Chronic hemodialysis services
8:39-2.11 Peritoneal dialysis
8:39-2.12 Add-a-bed

SUBCHAPTER 3. COMPLIANCE WITH MANDATORY RULES AND ADVISORY STANDARDS

8:39-3.1 Mandatory rules
8:39-3.2 Advisory standards
8:39-3.3 Reporting compliance with advisory standards

SUBCHAPTER 4. MANDATORY RESIDENT RIGHTS

8:39-4.1 Resident rights

SUBCHAPTER 5. MANDATORY ACCESS TO CARE

8:39-5.1 Mandatory admission policies and procedures
8:39-5.2 Mandatory policies and procedures for access to care

SUBCHAPTER 6. ADVISORY ACCESS TO CARE

8:39-6.1 Advisory admission policies and procedures

SUBCHAPTER 7. MANDATORY RESIDENT ACTIVITIES

8:39-7.1 Mandatory administrative organization for resident activities
8:39-7.2 Mandatory staff qualifications for resident activities
8:39-7.3 Mandatory staffing amounts and availability for activities
8:39-7.4 Mandatory resident activities services
8:39-7.5 Mandatory space and environment for resident activities

SUBCHAPTER 8. ADVISORY RESIDENT ACTIVITIES

8:39-8.1 Advisory policies and procedures for resident activities
8:39-8.2 Advisory staff qualifications for resident activities
8:39-8.3 Advisory staffing amounts and availability for resident activities
8:39-8.4 Advisory resident services for resident activities

SUBCHAPTER 9. MANDATORY ADMINISTRATION

8:39-9.1 Mandatory administrative organization and responsibilities
8:39-9.2 Mandatory policies and procedures for administration
8:39-9.3 Mandatory staff qualifications
8:39-9.4 Staffing amounts and availability
8:39-9.5 Mandatory policies and procedures for advance directives

SUBCHAPTER 10. ADVISORY ADMINISTRATION

8:39-10.1 Advisory policies and procedures for administration
8:39-10.2 Advisory staff qualifications
8:39-10.3 Advisory staff education and training

SUBCHAPTER 11. MANDATORY RESIDENT ASSESSMENT AND CARE PLANS

8:39-11.1 Mandatory completion of resident assessment and coordination of care plans
8:39-11.2 Mandatory policies and procedures for resident assessment and care plans
8:39-11.3 Mandatory resident services for discharge and transfer

SUBCHAPTER 12. ADVISORY RESIDENT ASSESSMENT AND CARE PLANS

8:39-12.1 Advisory policies and procedures for resident assessment and care plan
8:39-12.2 Advisory resident services for off-site services

SUBCHAPTER 13. MANDATORY COMMUNICATION

8:39-13.1 Mandatory communication policies and procedures
8:39-13.2 Mandatory resident communication services
8:39-13.3 Mandatory staff communication qualifications
8:39-13.4 Mandatory staff education and training for communication

SUBCHAPTER 14. ADVISORY COMMUNICATION

8:39-14.1 Advisory resident services
8:39-14.2 Advisory staff education and training for communication

SUBCHAPTER 15. MANDATORY DENTAL SERVICES

8:39-15.1 Mandatory resident dental services

SUBCHAPTER 16. ADVISORY DENTAL SERVICES

8:39-16.1 Advisory resident dental services

SUBCHAPTER 17. MANDATORY DIETARY SERVICES

8:39–17.1 Mandatory structural organization for dietary services
8:39–17.2 Mandatory policies and procedures for dietary services
8:39–17.3 Mandatory staff qualifications for dietary services
8:39–17.4 Mandatory staffing amounts and availability for dietary services
8:39–17.5 Mandatory resident dietary services

SUBCHAPTER 18. ADVISORY DIETARY SERVICES

8:39–18.1 Advisory structural organization for dietary services
8:39–18.2 Advisory staff qualifications for dietary services
8:39–18.3 Advisory staffing amounts and availability for dietary services
8:39–18.4 Advisory resident dietary services
8:39–18.5 Supplies and equipment

SUBCHAPTER 19. MANDATORY INFECTION CONTROL AND SANITATION

8:39–19.1 Mandatory organization for infection control and sanitation
8:39–19.2 Mandatory employee health policies and procedures for infection control and sanitation
8:39–19.3 Mandatory waste removal policies and procedures
8:39–19.4 Mandatory general policies and procedures for infection control and sanitation
8:39–19.5 Mandatory staff qualifications; health history and examinations
8:39–19.6 Mandatory space and environment for water supply
8:39–19.7 Mandatory space and environment for sanitation and waste management
8:39–19.8 Mandatory supplies and equipment for infection control and sanitation

SUBCHAPTER 20. ADVISORY INFECTION CONTROL AND SANITATION

8:39–20.1 Advisory policies and procedures for infection control
8:39–20.2 Advisory staff qualifications
8:39–20.3 Advisory staff education and training for infection control

SUBCHAPTER 21. MANDATORY LAUNDRY SERVICES

8:39–21.1 Mandatory laundry policies and procedures
8:39–21.2 Mandatory space and environment for laundry facilities
8:39–21.3 Mandatory supplies and equipment for laundry
8:39–21.4 Mandatory quality assurance for laundry

SUBCHAPTER 22. ADVISORY LAUNDRY SERVICES (RESERVED)

SUBCHAPTER 23. MANDATORY MEDICAL SERVICES

8:39–23.1 Mandatory structural organization for medical services
8:39–23.2 Mandatory resident care policies

SUBCHAPTER 24. ADVISORY MEDICAL SERVICES

8:39–24.1 Advisory medical staff qualifications
8:39–24.2 Advisory resident medical services

SUBCHAPTER 25. MANDATORY NURSE STAFFING

8:39–25.1 Mandatory policies and procedures for nurse staffing
8:39–25.2 Mandatory nurse staffing amounts and availability
8:39–25.3 Mandatory nursing staff qualifications
8:39–25.4 Mandatory nursing staff education and training

SUBCHAPTER 26. ADVISORY NURSE STAFFING

8:39–26.1 Advisory structural organization for nurse staffing
8:39–26.2 Advisory policies and procedures for nurse staffing
8:39–26.3 Advisory nurse staffing amounts and availability
8:39–26.4 Advisory qualifications for nurse staffing

SUBCHAPTER 27. MANDATORY QUALITY OF CARE

8:39–27.1 Mandatory policies and procedures and practices for quality of care
8:39–27.2 Mandatory policies and procedures for the use of restraints
8:39–27.3 Mandatory post-mortem policies and procedures
8:39–27.4 Mandatory staffing amounts and availability for resident care
8:39–27.5 Mandatory resident services for personal care
8:39–27.6 Mandatory general resident services
8:39–27.7 Mandatory supplies and equipment for resident care

SUBCHAPTER 28. ADVISORY QUALITY OF CARE

8:39–28.1 Advisory policies and procedures for resident care
8:39–28.2 Advisory resident care services

SUBCHAPTER 29. MANDATORY PHARMACY

8:39–29.1 Mandatory pharmacy organization
8:39–29.2 Mandatory drug administration policies and procedures
8:39–29.3 Mandatory pharmacy reporting policies and procedures
8:39–29.4 Mandatory pharmacy control policies and procedures
8:39–29.5 Mandatory pharmacy staff qualifications
8:39–29.6 Mandatory resident pharmacy services
8:39–29.7 Mandatory pharmacy supplies and equipment
8:39–29.8 Mandatory pharmacy quality assurance

SUBCHAPTER 30. ADVISORY PHARMACY

8:39–30.1 Advisory pharmacy staff qualifications
8:39–30.2 Advisory pharmacy staffing amounts and availability
8:39–30.3 Advisory pharmacy resident services
8:39–30.4 Advisory pharmacy quality assurance

SUBCHAPTER 31. MANDATORY PHYSICAL ENVIRONMENT

8:39–31.1 Mandatory space and environment; all facilities
8:39–31.2 Mandatory housekeeping policies and procedures
8:39–31.3 Mandatory supplies and equipment
8:39–31.4 Mandatory staff qualifications for housekeeping

SUBCHAPTER 32. ADVISORY PHYSICAL ENVIRONMENT

8:39–32.1 Advisory smoking policies and procedures
8:39–32.2 Advisory physical environment for resident services
8:39–32.3 Advisory space and environment for all facilities
8:39–32.4 Advisory supplies and equipment

SUBCHAPTER 33. MANDATORY QUALITY ASSESSMENT AND ASSURANCE

8:39–33.1 Mandatory quality assurance structural organization
8:39–33.2 Mandatory quality assurance policies and procedures
8:39–33.3 Mandatory quality assurance resident services
8:39–33.4 Mandatory quality assurance staff education and training

SUBCHAPTER 34. ADVISORY QUALITY ASSESSMENT AND ASSURANCE

8:39–34.1 Advisory quality assessment and assurance policies and procedures

SUBCHAPTER 35. MANDATORY MEDICAL RECORDS

8:39–35.1 Mandatory organization for medical records
8:39–35.2 Mandatory policies and procedures for medical records

SUBCHAPTER 36. ADVISORY MEDICAL RECORDS

8:39–36.1 Advisory policies and procedures for medical records
8:39–36.2 Advisory staff education and training for medical records
8:39–36.3 Advisory staff qualifications for medical records

SUBCHAPTER 37. MANDATORY REHABILITATION

8:39–37.1 Mandatory policies and procedures for rehabilitation
8:39–37.2 Mandatory rehabilitation staff qualifications
8:39–37.3 Mandatory rehabilitation staffing amounts and availability
8:39–37.4 Mandatory rehabilitation supplies and equipment

SUBCHAPTER 38. ADVISORY REHABILITATION

8:39–38.1 Advisory rehabilitation staff qualifications
8:39–38.2 Advisory rehabilitation space and environment
8:39–38.3 Advisory rehabilitation supplies and equipment

SUBCHAPTER 39. MANDATORY SOCIAL WORK

8:39–39.1 Mandatory social work policies and procedures
8:39–39.2 Mandatory social work staff qualifications
8:39–39.3 Mandatory social work amounts and availability
8:39–39.4 Mandatory resident social work services
8:39–39.5 Mandatory space and environment for social work

SUBCHAPTER 40. ADVISORY SOCIAL WORK

8:39–40.1 Advisory staff qualifications for social work
8:39–40.2 Advisory staff amounts and availability for social work
8:39–40.3 Advisory resident social work services
8:39–40.4 Advisory space and environment for social work
8:39–40.5 Advisory social work staff education and training

SUBCHAPTER 41. MANDATORY PHYSICAL PLANT

8:39–41.1 Mandatory construction standards
8:39–41.2 Mandatory general maintenance
8:39–41.3 Mandatory fire and emergency preparedness
8:39–41.4 Mandatory safety requirements

SUBCHAPTER 42. ADVISORY PHYSICAL PLANT

8:39–42.1 Advisory general maintenance
8:39–42.2 Advisory fire and emergency preparedness
8:39–42.3 Advisory safety

SUBCHAPTER 43. NURSE AIDE IN LONG-TERM CARE FACILITIES TRAINING AND COMPETENCY EVALUATION PROGRAM

8:39–43.1 Fees
8:39–43.2 Nurse aide employment
8:39–43.3 Nurse aide functions
8:39–43.4 Approval of nurse aide in long-term care facilities training program
8:39–43.5 The New Jersey Curriculum for Nurse Aide Personnel in Long-Term Care Facilities
8:39–43.6 Responsibilities of administrator
8:39–43.7 Nurse aide training program instructors
8:39–43.8 Student records and attendance
8:39–43.9 Training program evaluation
8:39–43.10 Competency examination
8:39–43.11 Application to take the competency examination and for certification as a nurse aide in long-term care facilities
8:39–43.12 Waiver of requirement to complete training program
8:39–43.13 Certificates
8:39–43.14 Revocation of a certificate
8:39–43.15 Recertification
8:39–43.16 Nurse aide registry
8:39–43.17 Hearings for resident abuse, resident neglect, or misappropriation of property
8:39–43.18 Equivalency for nurse aides registered in other states
8:39–43.19 Expiration of certification
8:39–43.20 Employment of a nurse aide

SUBCHAPTER 44. RESPITE CARE SERVICES

8:39–44.1 Scope and purpose
8:39–44.2 Mandatory policies and procedures
8:39–44.3 Advisory staffing

SUBCHAPTER 45. ALZHEIMER'S/DEMENTIA PROGRAMS—MANDATORY STANDARDS

8:39–45.1 Scope and purpose

SUBCHAPTER 46. ALZHEIMER'S/DEMENTIA PROGRAMS—ADVISORY STANDARDS

8:39–46.1 Advisory Alzheimer's/dementia program policies and procedures
8:39–46.2 Advisory staffing
8:39–46.3 Advisory environmental modification
8:39–46.4 Advisory activity programming
8:39–46.5 Advisory nutrition
8:39–46.6 Advisory social services

APPENDIX A GUIDELINES AND CONSIDERATIONS FOR PET FACILITATED THERAPY IN NEW JERSEY INSTITUTIONS

APPENDIX B GUIDELINES FOR THE MANAGEMENT OF INAPPROPRIATE BEHAVIOR AND RESIDENT TO RESIDENT ABUSE

APPENDIX C HOSPITAL AND NURSING HOME PATIENT TRANSFER FORM AND PLAN OF CARE

APPENDIX D MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)

APPENDIX E GUIDELINES FOR THE USE OF RESTRAINTS

SUBCHAPTER 1. GENERAL PROVISIONS

8:39–1.1 Scope and purpose

(a) This chapter contains rules and standards intended to assure the high quality of care delivered in long-term care facilities, commonly known as nursing homes, throughout New Jersey. Components of quality of care addressed by these rules and standards include access to care, continuity of care, comprehensiveness of care, coordination of services, humaneness of treatment, conservatism in intervention, safety of the environment, professionalism of caregivers, and participation in useful studies.

(b) These rules and standards apply to each licensed long-term care facility. They are intended for use in State surveys of the facilities and any ensuing enforcement actions. They are also designed to be useful to consumers and providers as a mechanism for privately assessing the quality of care provided in any long-term care facility.

Law Review and Journal Commentaries

Nursing Homes in the Garden State: A Legal Perspective. Janice Chapin, 141 N.J.Law. 38 (Mag.) (July/August 1991).

Case Notes

Nursing home was not exempt as "hospital" from local property tax. Intercare Health Systems, Inc. v. Cedar Grove Tp., 11 N.J.Tax 423 (1990), affirmed 12 N.J.Tax 273, certification denied 127 N.J. 558, 606 A.2d 369.

For nursing home to qualify as "hospital" exempt from property tax, home must be integral part of functioning hospital. Intercare Health Systems, Inc. v. Cedar Grove Tp., 11 N.J.Tax 423 (1990), affirmed 12 N.J.Tax 273, certification denied 127 N.J. 558, 606 A.2d 369.

Former long-term care facility regulations at N.J.C.A. 8:30–14 are valid. In Review of Health Care Administration Board v. Finley, 168 N.J.Super. 152 (App.Div.1979), affirmed 83 N.J. 67 (1980), 449 U.S. 944, 402 A.2d 246 (1980).

Building owned by nonprofit corporation and used as long-term nursing care facility and residential unit was not entitled to "charitable purposes" exemption from property taxation. Woodstown Borough v. Friends Home at Woodstown, 12 N.J.Tax 197 (1992).

8:39–1.2 Definitions

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

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

"Available" means ready for immediate use (pertaining to equipment) or capable of being reached (pertaining to personnel), unless otherwise defined in these rules.

"Bed" or "licensed bed" means, with reference to a resident, the item of furniture assigned to no more than one resident for sleeping, resting, relaxing, or otherwise used for the resident's personal comfort or convenience, and with reference to a facility, one of the total number of beds for which each licensed long-term care facility is approved for resident care by the Commissioner of the New Jersey State Department of Health.

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

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

"Communicable disease" means an illness due to a specific infectious agent or its toxic products which occurs through transmission of that agent or its products from a reservoir to a susceptible host.

"Conspicuously posted" means placed at a location within the facility accessible to and seen by residents and the public.

"Contamination" means the presence of an infectious or toxic agent in the air, on a body surface, or on or in clothes, bedding, instruments, dressings, or other inanimate articles or substances, including water, milk, and food.

"Controlled Dangerous Substances Acts" means the Controlled Substances Act of 1970 (Title II, Public Law 91–513) and the New Jersey Controlled Dangerous Substances Act of 1971, N.J.S.A. 24:21–1 et seq.

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

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

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

"Documented" means written, signed, and dated. If an identifier such as a master sign-in sheet is used, initials may be used for signing documentation, in accordance with applicable professional standards of practice.

"Drug administration" means a procedure in which a prescribed drug or biological is given to a resident 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 prescriber's orders, giving the individual dose to the resident, seeing that the resident takes it (if oral), and recording the required information, including the method of administration.

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

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

"Facility" means a facility or distinct part of a facility licensed by the New Jersey State Department of Health to provide health care under medical supervision and continuous nursing supervision for 24 or more consecutive hours to two or more residents who are not related to the members of the governing authority by marriage, blood, or adoption; who do not require the degree of care and treatment which a hospital provides; and who, because of their physical or mental condition, require continuous nursing care and services above the level of room and board.

"Federal Level A deficiency" means a failure to comply with one or more of the requirements indicated by those tag numbers in document 42 CFR Part 483 S483.5 which are followed by an "A" suffix.

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

"Guardian" means a person appointed by a court of competent jurisdiction to handle the affairs and protect the rights of any resident of the facility.

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

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

"Medication error" means the administration of the wrong medication or dose of medication, drug, diagnostic agent, chemical or treatment requiring use of such agents to the wrong resident, or at the wrong time, or the failure to administer such agents at the specified time, or in the manner prescribed or normally considered as accepted practice. Errors may be classified as "commissions," that is, medications incorrectly administered to the resident, such as unordered medication or medication in the wrong strength; and "omissions," that is, medications not administered at prescribed times.

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

"Physician" means a person licensed to practice medicine by the New Jersey State Board of Medical Examiners.

"Reasonable hour" means any time between the hours of 8:00 A.M. and 8:00 P.M. daily.

"Resident" means a person who resides in the facility and is in need of 24–hour continuous nursing supervision.

"Self administration" means a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a resident to himself or herself. The complete procedure of self-administration includes removing an individual dose from a previously dispensed (in accordance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39), 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.

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

"Signature" means at least the first initial and full surname and title (for example, R.N., L.P.N., D.D.S., M.D., D.O.) of a person, legibly written with his or her own hand. A controlled electronic signature system may be used.

"Supervision" means authoritative procedural guidance by a qualified person for the accomplishment of a function or activity within his or her sphere of competence, with initial direction and periodic on-site inspection of the actual act of accomplishing the function or activity. "Direct supervision" means supervision on the premises within view of the supervisor.

"Unit-of-use" means a system in which drugs are delivered to the resident areas either in single unit packaging, bingo or punch cards, blister or strip packs, or other system where each drug is physically separate.

SUBCHAPTER 2. LICENSURE PROCEDURE

8:39–2.1 Certificate of Need

(a) According to the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H–1 et seq., and amendments thereto, a health care facility shall not be instituted, constructed, expanded, or licensed to operate except upon application for and receipt of a Certificate of Need issued by the Commissioner, in accordance with N.J.A.C. 8:33. Facilities exempt from Certificate of Need pursuant to law, shall follow licensing procedures identified in N.J.A.C. 8:39–2.2 below.

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

Certificate of Need Review Services
Division of Health Planning, Financing and Information Services
New Jersey State Department of Health
CN 360
Trenton, NJ 08625–0367

(c) The facility shall implement all conditions imposed by the Commissioner as specified in the Certificate of Need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H–1 et seq., and amendments thereto.

8:39–2.2 Application for licensure

(a) Following acquisition of a Certificate of Need, or a determination that a Certificate of Need is not required, any person, organization, or corporation desiring to operate a facility shall make application to the Commissioner for a license on forms prescribed by the Department which include information regarding facility ownership, corporate officers and stockholders, and approval forms from local building, fire, health and zoning departments. Such forms may be obtained from:

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

(b) The Department shall charge a nonrefundable fee of $500.00 plus $3.00 per bed for the filing of an application for licensure of a long-term care facility. The Department shall also charge a nonrefundable fee of $500.00 plus $3.00 per bed for the annual renewal of the license.

(c) If chronic dialysis services are provided in the long-term care facility, the Department shall charge an initial licensure application fee of $500.00 and an additional $150.00 annually for licensure of the service. (The initial application shall be accompanied by a $650.00 fee; thereafter, $150.00 will be added to the facility's annual licensure renewal fee.)

(d) Any person, organization, or corporation 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.

(e) The Department shall examine and evaluate the licensing track record of each applicant for the period beginning 12 months preceding submission of the application for licensure and extending to the date the Commissioner issues a final decision, for the purpose of determining the capacity of an applicant to operate a health care facility in a safe and effective manner in accordance with State and Federal requirements. A license may be denied where an applicant has not demonstrated such capacity, as evidenced by continuing or serious violations of State licensure standards or Federal certification standards or by existence of a criminal conviction or a plea of guilty to a charge of fraud, resident abuse or neglect, or crime of violence or moral turpitude. An applicant, for purposes of this rule, includes any person who was or is an owner or principal of a licensed health care facility, or who has managed, operated, or owned in whole or in part any health care facility, excluding individuals or entities who are limited partners with no managerial control or authority over the operation of the facility and who have an ownership interest of five percent or less in a corporation which is the applicant and who also do not serve as officers or directors of the applicant corporation.

(f) An application for licensure submitted by an applicant who was cited for state licensing or Federal certification deficiencies during the period identified in (e) above, which presented a serious risk to the life, safety, or quality of care of the facility's residents shall be denied. A serious risk to life, safety, or quality of care of residents includes, but is not limited to, deficiencies in state licensure or Federal certification requirements in the areas of nursing, resident rights, resident assessment or care plan, dietary services, infection control and sanitation, or pharmacy, resulting in:

1. An action by a state or Federal agency to curtail or temporarily suspend admissions to the facility;

2. Issuance of two or more Federal level A deficiencies in the areas identified above; or

3. Issuance of one or more Federal level A deficiencies in the same area on two or more consecutive visits.

(g) In evaluating track records in (e) or (f) above, the Department may consider any evidence of non-compliance with applicable licensure requirements provided by an official state licensing agency in any state other than New Jersey, or any official records from any agency of the State of New Jersey indicating the applicant's non-compliance with the agency's licensure or certification requirements in a facility the applicant owned, operated, or managed in whole or in part.

(h) An applicant who owns, operates, or manages in whole or in part five or more health care facilities licensed or certified to operate in any state, including New Jersey, may be exempt from mandatory CN denial provisions of N.J.A.C. 8:33H–1.14(d), or (e) and (f) above under the following conditions:

1. No more than one out-of-State facility has the violations enumerated in (f)1, 2, and 3 above. In no case shall the applicant's New Jersey facility have such violations;

2. The applicant establishes a trust account or an irrevocable letter of credit in the favor of the Department in the amount of two percent of project costs or $200,000, whichever is greater, except that applicants whose project costs are less than $400,000 shall be permitted to post a bond or trust account equal to 50 percent of total project costs or $100,000, whichever is greater;

3. The trust account or irrevocable letter of credit shall be established through an entity approved by the Department and be written in a form that is approved by the Department;

4. The trust fund or irrevocable letter of credit shall have named as beneficiary The Health Care Facilities Improvement Fund, as administered by the Department;

5. The funds shall remain in the irrevocable letter of credit, or trust fund pursuant to the following schedule:

i. For a period of 15 months from the date the Department approves initial occupancy and operation of the facility in the event the certificate of need is approved;

ii. If the applicant does not obtain certificate of need approval for the project, the irrevocable letter of credit or trust fund shall expire after all avenues of relief pursuant to certificate of need denial appeal rights are exhausted or waived.

6. If none of the conditions enumerated in (f)1, 2 or 3 above are found during any survey occurring during the initial one year period, the funds and any accrued interest shall be returned to the applicant;

7. If during the one year period from initial approved occupancy, a violation of the type enumerated in (f)1, 2 or 3 above is found in the subject facility, then all funds in the line of credit or trust fund shall accrue to the benefit of The Health Care Facilities Improvement Fund;

8. The one year period in (a)7 above may be extended by the Department for an additional three months if a single level A violation is found in the areas identified in (d) during the initial 12 months of operation.

(i) Any applicant denied a license to operate a facility shall have the right to a fair hearing in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

Amended by R.1995 d.127, effective March 6, 1995.
See: 26 N.J.R. 1772(c), 27 N.J.R. 937(b).

8:39–2.3 Newly constructed or expanded facilities

(a) The application for a license pursuant to N.J.A.C. 8:39–2.2 for the operation of a new facility shall include written approval of final construction of the physical plant by:

Health Facilities Construction Service
Division of Health Facilities Evaluation
New Jersey State Department of Health
CN 367
Trenton, NJ 08625–0367

(b) A final on-site inspection of the construction of the physical plant shall be made by representatives of the Health Care Facilities Construction Service and the Health Facilities Inspection Program, to verify that the building has been constructed in accordance with the final architectural plans approved by the Department, in accordance with N.J.A.C. 8:39–41.

(c) Any health care facility with a construction program, whether a Certificate of Need is required or not, shall submit plans to the Health Facilities Construction Service of the Department for review and approval prior to the initiation of any work.

8:39–2.4 Surveys and temporary license

(a) When the written application for licensure pursuant to N.J.A.C. 8:39–2.2 is approved and the building is ready for occupancy, a survey of the facility by representatives of the Health Facilities Inspection Program of the Department shall be conducted to determine if the facility meets the standards set forth in this chapter.

1. The Health Facilities Inspection Program of the Department shall notify the facility in writing of the findings of the survey, including any deficiencies found.

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

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

1. An office conference for review of the conditions for licensure and operation has taken place between the Licensing, Certification and Standards Program and representatives of the facility, who have been advised that the purpose of the temporary license is to allow the Department to determine the facility's compliance with the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H–1 et seq., and amendments thereto, and the rules pursuant thereto;

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

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

4. Survey(s) by representatives of the Department indicate that the facility meets the mandatory standards set forth in this chapter.

(c) No health care facility shall accept residents until the facility has written approval and/or a license issued by the Licensing, Certification and Standards Program of the Department.

(d) The facility shall accept no more than that number of residents for which it is approved and/or licensed.

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

(f) Upon compliance with N.J.A.C. 8:39–2.2(e), a temporary license shall be issued to the operator of a facility for a period of six months and shall be renewed as determined by the Department, based upon the achievement of a substantial degree of compliance with this chapter.

1. The temporary license shall be conspicuously posted in the facility.

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

8:39–2.5 Full license

(a) A full license shall be issued to the operator on expiration of the temporary license, if the surveys by the Department have determined that the health care facility is operated as required by the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H–1 et seq., and amendments thereto, and by the rules pursuant thereto.

(b) A license shall be granted for a period of one year or less as determined by the Department in accordance with (a) above.

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

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

(e) The license, 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, in accordance with the following:

1. The facility shall receive a request for renewal fee as provided in N.J.A.C. 8:39–2.2(b) 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; and

2. The license shall not be renewed if local regulations or any other requirements are not met which substantially affect the provision of services as required by this chapter.

8:39–2.6 Surrender of license

The facility shall obtain any required Certificate of Need and shall directly notify each resident, the resident's physician, and any guarantors of payment 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 licensure. In such cases, the license shall be returned to the Licensing, Certification and Standards Program of the Department within seven calendar days from voluntary surrender, order of revocation, expiration, or suspension of license, whichever is applicable.

8:39–2.7 Waiver

(a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H–1 et seq., and amendments thereto, and the standards in this chapter, waive sections of this chapter if, in his or her opinion, such waiver would not endanger the life, safety, or health of the resident or public.

(b) A facility seeking a waiver of the standards in this chapter shall apply in writing to the Director of the Licensing, Certification and Standards Program of the Department.

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

1. The nature of the waiver requested;

2. The specific standards for which a waiver is requested;

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;

4. An alternative proposal which would ensure resident safety; and

5. Documentation to support the application for waiver.

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

8:39–2.8 Action against licensee

(a) Violations of this subchapter may result in action by the New Jersey State Department of Health to impose a fine, cease admissions to a facility, remove residents from a facility, revoke a license, and/or impose other lawful remedies.

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

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

(d) This section shall apply to all facilities.

(e) Any licensee made subject to action by the Department under terms of this section shall have the right to a fair hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq., and the Uniform Administrative Procedures Rules, N.J.A.C. 1:1.

8:39–2.9 Special long-term care services

(a) A facility which proposes to establish a distinct or designated special service, program, or unit in which the facility will advertise or hold itself out as offering specialized care services, program(s), or unit(s) shall receive a determination from the Department, on a case-by-case basis, as to whether a Certificate of Need is required prior to initiating any such services or programs in the facility.

(b) Following receipt of an approved Certificate of Need or written determination that no Certificate of Need is required, the facility shall submit a program description to the Division of Health Facilities Evaluation and Certification prior to implementing services, which includes the following information:

1. Specific population to be served (diagnoses or behavioral conditions, estimated census in program);

2. Specific services to be offered in addition to existing nursing facility program;

3. Staffing patterns, which shall include a registered professional nurse on duty at all times; and

4. Unit or area to be utilized within the facility and identification of any renovations to be completed.

(c) A specialized care service, unit or program means a distinct or designated area or unit of the facility, or a defined and identifiable program of services which serves the unique and special health and personal care needs of an identifiable group of residents within the facility. Special care programs existing on or before adoption of this chapter that are under a special provider contract with the Division of Medical Assistance and Health Services, Department of Human Services, or who have previously received Certificate of Need approval, or have been issued authorization as an Alzheimer's/dementia program under (f) below and N.J.A.C. 8:39–45, are exempt from the requirements of (a) and (b) above.

(d) The Department may impose operational standards derived from the plan submitted by the facility and from other adopted licensure rules appropriate to the specialized population, including Division of Medical Assistance and Health Services rules, as a condition on the issuance of a license. Such conditions are subject to the enforcement actions and procedures specified at N.J.A.C. 8:39–2.8.

(e) In the case of specialized care units proposing to treat ventilator dependent residents, the facility shall provide staffing for the nursing unit upon which the ventilator beds are located as follows:

1. At least one registered professional nurse shall be present on the unit 24 hours per day; and

2. At least one respiratory care practitioner who is currently licensed to practice by the New Jersey Board of Respiratory Care shall be present on the unit 24 hours per day.

(f) A Department approved Alzheimer's/dementia program means an organized plan of special services which may be provided to residents who are located either in a distinct physical unit or integrated throughout the existing facility. A facility proposing to establish an Alzheimer's/dementia program shall comply with the following program requirements:

1. No facility shall advertise or hold itself out as providing an Alzheimer's/dementia program unless it is recognized by the Department of Health as meeting at least 65 percent of all current advisory standards in N.J.A.C. 8:39–46.1 through 46.6, Advisory Alzheimer's/dementia programs; and

2. A facility seeking to establish an Alzheimer's/dementia unit or program shall obtain a determination of whether a Certificate of Need is required prior to establishment of or implementing the program, in accordance with N.J.A.C. 8:33H–1.7. An Alzheimer's/dementia program alone shall not constitute a new health care service within the meaning of N.J.A.C. 8:33–1.6 or 2.6 and shall not be eligible for increased reimbursement as a special care program funded through the Division of Medical Assistance.

(g) Any special care service, program or unit shall be identified on the facility's license.

8:39–2.10 Chronic hemodialysis services

(a) If the facility provides hemodialysis services to its own long-term care residents only, the following conditions shall be met:

1. The facility shall be authorized to provide the service by the Licensing Program of the Department of Health subsequent to the submission and review of the information contained in this subchapter. The application shall describe how the standards in (a)2 through 4 below will be met. The facility shall comply with ambulatory care requirements for a chronic dialysis provider, in accordance with N.J.A.C. 8:43A–24, and the application shall describe how such compliance will be achieved. Waivers from the nine station minimum requirement at N.J.A.C. 8:43A–24.2 will be considered on an individual basis;

2. A consultant nephrologist who is Board Certified or Board eligible shall be designated and available to provide medical direction for the hemodialysis service;

3. The facility shall identify the space where hemodialysis services will be provided;

i. Identified space shall be in compliance with the requirements at N.J.A.C. 8:43A–24, Licensure Standards for Ambulatory Care;

ii. If bedside hemodialysis services are offered, they shall be provided only in private rooms; and

4. Hemodialysis shall be listed as a "service" on the facility's license.

(b) If the facility or other separately licensed dialysis provider provides outpatient dialysis services on-site to persons who are not residents of the facility, the following conditions shall be met:

1. The facility shall file a licensing application in order to be authorized to provide the service. The facility shall comply with ambulatory care regulations for chronic dialysis services, in accordance with N.J.A.C. 8:43A, particularly N.J.A.C. 8:43A–24, and the application shall describe how such compliance will be achieved;

2. Outpatient records shall be kept separately from inpatient records; and

3. The hemodialysis program shall not utilize any space required by the long-term care program, such as passageways, corridors, or treatment room, and shall not require the commingling of hemodialysis patients with facility residents.

(c) Hemodialysis services may be provided to residents of the long-term care facility by separately licensed dialysis providers under the following circumstances:

1. The dialysis provider shall file a licensing application in order to be authorized to provide the service. The facility shall comply with ambulatory care requirements for chronic dialysis services, in accordance with N.J.A.C. 8:43A, particularly N.J.A.C. 8:43A–24, and the application shall describe how such compliance will be achieved;

2. The provider shall demonstrate the ability to serve nine patients Statewide within six months of licensing approval;

3. The provider shall have a New Jersey office or execute a jurisdictional agreement with the Department;

4. The provider shall describe all staffing, and how staffing will be provided at multiple sites, if applicable;

5. A copy of the contract between the dialysis provider and the long-term care facility shall be included with the licensing application. The contract shall clearly state the roles and responsibilities of both the dialysis provider and the long-term care facility. Any change in dialysis provider shall require prior authorization and submission of a separate licensure application by the dialysis provider;

6. The Department shall charge a fee for licensure of the dialysis service as an Ambulatory Care Facility in accordance with N.J.A.C. 8:43A–2.2(b). (Each site of service provision shall be considered a satellite);

7. Hemodialysis shall be listed as a "service" on the facility's license; and

8. Both the provider and the long-term care facility shall inform the Department in writing 30 days prior to any planned service interruption and shall include a plan for the continuing care of any dialysis patients.

(d) Any long-term care facility which proposes to offer hemodialysis services through a separately licensed dialysis provider shall also comply with the following requirements:

1. The facility shall request written authorization from the Licensing Program to contract with a licensed outside provider prior to implementing the service and specify the provider. A copy of the contract between the dialysis provider and the long-term care facility shall be included with the licensing application. The contract shall clearly state the roles and responsibilities of both the dialysis provider and the long-term care facility. Any change in dialysis provider shall require prior authorization and submission of a separate licensure application by the new dialysis provider;

2. The facility shall identify the space in which the service will be provided, including documentation that the space meets the requirements of N.J.A.C. 8:43A–24. Any renovations or construction shall receive prior approval from the Department. Space required by the long-term care facility programs shall not be used; and

3. The Department shall charge a fee of $150.00, which shall accompany the information required at (d)1 and 2 above. Thereafter, $150.00 shall be added to the usual annual licensing fee and the license shall list chronic dialysis as a service provided under contract with a dialysis provider.

8:39–2.11 Peritoneal dialysis

(a) If a long-term care facility offers peritoneal renal dialysis services to its own residents only, the following conditions shall be met:

1. A licensing application shall not be required;

2. The facility shall forward to the Department an attestation that the information listed below is available at the facility for review. Following receipt of this attestation, authorization to provide the service may be granted:

i. Policies and procedures for service provision, which shall include the following:

(1) Staff qualifications and training;

(2) Admission criteria;

(3) Transfer agreement with a certified ESRD hospital facility;

(4) Quality assurance mechanisms and criteria;

(5) Infection prevention and control, including bag disposal;

(6) Emergency situations;

(7) Dietary requirements; and

(8) How and where any necessary laboratory work will be completed.

3. A consultant nephrologist shall be designated and available to provide medical direction for the service; and

4. Peritoneal dialysis shall be listed as a "service" on the facility's license.

(b) Separately licensed dialysis providers may offer peritoneal dialysis services in a long-term care facility under the following circumstances:

1. All requirements in (a) above shall be met;

2. The dialysis provider shall be licensed as specified at N.J.A.C. 8:39–2.10(c);

3. A copy of the contract agreement for service provision between the dialysis provider and the long-term care facility shall be reviewed and approved by the Licensing Program of the Department prior to the authorization of the long-term care facility to provide the service through a separately licensed agency. The agreement shall clearly state the roles and responsibilities of both parties; and

4. Both the long-term care facility and the dialysis agency shall notify the Department in writing 30 days prior to any planned service interruption and shall include a plan for the continuing care of any dialysis patients.

8:39–2.12 Add-a-bed

(a) Pursuant to N.J.S.A. 26:2H–7.2, a facility may request approval from the Department to increase total licensed beds by no more than 10 beds or 10 percent of its licensed bed capacity, whichever is less, without Certificate of Need approval. No more than one such request for approval shall be submitted every five years.

(b) The application shall be filed, with an application fee of $250.00, using application forms provided by the Licensing, Certification and Standards program, and shall include: name, address, ownership, and any other facilities owned, licensed capacity, any existing waivers, number of beds requested, proposed location of beds, any construction/renovation needed, a description of the project, number of single-bed rooms and square footage of dining/recreation area after increase, and additional staffing required.

(c) The Department shall deny an application for add-a-beds based on the facility track record, if any of the following criteria:

1. Within the last 12 months preceding the date of application, the applicant was cited for a violation of the licensing rules in this chapter or of Federal certification requirements for Medicaid or Medicare participation which presented a serious risk to the life, safety, or quality of care of the facility's residents. A serious risk to life, safety, or quality of care of residents includes, but is not limited to, deficiencies in State licensure or Federal certification requirements in the areas of nursing, resident rights, resident assessment and care plans, dietary services, infection control and sanitation, or pharmacy, resulting in:

i. An action by a State or Federal agency to curtail or temporarily suspend admissions to a facility; or

ii. Issuance of two or more Federal Level A deficiencies in the areas identified above; or

iii. Issuance of one or more Federal Level A deficiencies in the same area on two or more consecutive visits; or

2. The applicant fails to demonstrate that the facility has sufficient space to implement the new licensed bed capacity in a manner meeting Federal construction standards contained in the Guidelines for Construction and Equipment of Hospital and Medical Facilities (1992–1993), as published by the American Institute of Architects and approved by the U.S. Department of Health and Human Services. (Available from the American Institute of Architects Press, 1735 New York Ave., NW, Washington, D.C. 20006); or

3. The applicant fails to demonstrate that the facility has provided sufficient nurse staffing hours, in accordance with this chapter, to meet the needs of the current resident census; or

4. The addition of beds will result in a unit size in excess of 64 beds; or

5. The addition of beds will result in a violation of State licensure or Federal certification requirements.

Amended by R.1995 d.127, effective March 6, 1995.
See: 26 N.J.R. 1772(c), 27 N.J.R. 937(b).

SUBCHAPTER 3. COMPLIANCE WITH MANDATORY RULES AND ADVISORY STANDARDS

8:39–3.1 Mandatory rules

(a) Mandatory rules contain minimum and essential requirements of care provided by a facility.

(b) Failure to comply with any mandatory rules contained in this chapter shall constitute a deficiency for which the New Jersey State Department of Health may take any or all of the following measures or any other lawful remedy:

1. Action to impose a fine;

2. Cessation of all admissions;

3. Removal of residents from the facility when there is an imminent danger to any person's health or safety; and

4. Revocation of the license held by the facility's operator.

8:39–3.2 Advisory standards

(a) Advisory standards contain benchmarks of excellence or superior attainment in providing care of high quality.

(b) Facilities are strongly encouraged to use advisory standards in striving to provide the highest quality of care possible.

(c) Failure to comply with any or all advisory standards shall not constitute a deficiency or result directly or indirectly in any fine, cessation of admissions, removal of residents, or revocation of a license, imposed pursuant to action by the New Jersey State Department of Health.

(d) Compliance with advisory standards shall not be used as an indication of whether the facility is in compliance with mandatory rules or whether a facility should be made subject to a penalty or other action to protect residents.

8:39–3.3 Reporting compliance with advisory standards

(a) Compliance with advisory standards shall be calculated in accordance with the following:

1. The Department shall verify that at least 90 percent of no more than 30 advisory standards randomly selected from the total number of advisory standards which the facility claims to have met are in fact met; and

2. If the compliance rate determined at (a)1 above is 90 percent or greater, then, for any advisory subchapter in which the facility has claimed to meet 65 percent or more of the standards in the subchapter, recognition for meeting the entire subchapter shall be given.

(b) Reports of individual facilities' compliance with advisory standards shall be available at the New Jersey State Department of Health, Office of Licensing and Inspection, for the inspection of the public, during normal business hours.

(c) If a facility applies for a Certificate of Need, compliance with six or more of the following advisory subchapters at the time of the most recent survey of the facility will be taken into consideration: access to care (N.J.A.C. 8:39–6), resident assessment and care plans (N.J.A.C. 8:39–12), pharmacy (N.J.A.C. 8:39–30), infection control and sanitation (N.J.A.C. 8:39–20), resident activities (N.J.A.C. 8:39–8), dietary services (N.J.A.C. 8:39–18), medical services (N.J.A.C. 8:39–24), nurse staffing (N.J.A.C. 8:39–26), physical environment (N.J.A.C. 8:39–32), and quality assessment and assurance (N.J.A.C. 8:39–34).

(d) If a facility can demonstrate that it has a system in place to meet the requirement, even though it is not applicable at the time of the survey, the surveyors may deem that, in their judgment, the standard is met.

SUBCHAPTER 4. MANDATORY RESIDENT RIGHTS

8:39–4.1 Resident rights

(a) Each resident shall be entitled to the following rights:

1. To retain the services of a physician the resident chooses, at the resident's own expense or through a health care plan;

2. To have a physician explain to the resident, in language that the resident understands, his or her complete medical condition, the recommended treatment, and the expected results of the treatment, except when the physician deems it medically inadvisable to give such information to the resident and records the reason for such decision in the resident's medical record; and provides an explanation to his or her next of kin or guardian;

3. To participate, to the fullest extent that the resident is able, in planning his or her own medical treatment and care;

4. To refuse medication and treatment after the resident has been informed, in language that the resident understands, of the possible consequences of this decision. The resident may also refuse to participate in experimental research, including the investigations of new drugs and medical devices. The resident shall be included in experimental research only when he or she gives informed, written consent to such participation;

5. To be free from physical and mental abuse;

6. To be free from chemical and physical restraints, unless they are authorized by a physician for a limited period of time to protect the resident or others from injury. Under no circumstances shall the resident be confined in a locked room or restrained for punishment, for the convenience of the nursing home staff, or with the use of excessive drug dosages;

7. To manage his or her own finances or to have that responsibility delegated to a family member, an assigned guardian, the nursing home administrator, or some other individual with power of attorney. The resident's authorization must be in writing, and must be witnessed in writing;

8. To receive a written statement or admission agreement describing the services provided by the nursing home and the related charges. Such statement or admission agreement must be in compliance with all applicable State and Federal laws. This statement or agreement must also include the nursing home's policies for payment of fees, deposits, and refunds. The resident shall receive this statement or agreement prior to or at the time of admission, and afterward whenever there are any changes;

9. To receive a quarterly written account of all resident's funds and itemized property that are deposited with the facility for the resident's use and safekeeping and of all financial transactions with the resident, next of kin, or guardian. This record must also show the amount of property in the account at the beginning and end of the accounting period, as well as a list of all deposits and withdrawals, substantiated by receipts given to the resident or his or her guardian;

10. To have daily access during specified hours to the money and property that the resident has deposited with the nursing home. The resident also may delegate, in writing, this right of access to his or her representative;

11. To live in safe, decent, and clean conditions in a nursing home that does not admit more residents than it can safely accommodate while providing adequate nursing care;

12. To be treated with courtesy, consideration, and respect for the resident's dignity and individuality;

13. To receive notice of an intended transfer from one room to another within the facility or a change in roommate, including a right to an informal hearing with the administrator prior to the transfer as well as a written statement of the reasons for such transfer. The nursing home shall not move the resident to a different bed or room in the facility if the relocation is arbitrary and capricious. A transfer would not be considered arbitrary and capricious if a facility can document a clinical necessity for relocating the resident, such as a need for isolation or to address behavior management problems, or there is a hardship to an applicant for admission through a delay caused by inefficient distribution of beds by gender.

14. To wear his or her own clothes, unless this would be unsafe or impractical. All clothes provided by the nursing home must fit in a way that is not demeaning to the resident;

15. To keep and use his or her personal property, unless this would be unsafe, impractical, or an infringement on the rights of other residents. The nursing home shall take precautions to ensure that the resident's personal possessions are secure from theft, loss, and misplacement;

16. To have physical privacy. The resident shall be allowed, for example, to maintain the privacy of his or her body during medical treatment and personal hygiene activities, such as bathing and using the toilet, unless the resident needs assistance for his or her own safety;

17. To have reasonable opportunities for private and intimate physical and social interaction with other people, including arrangements for privacy when the resident's spouse visits. If the resident and his or her spouse are both residents of the same nursing home, they shall be given the opportunity to share a room, unless this is medically inadvisable, as documented in their records by a physician;

18. To confidential treatment of information about the resident. Information in the resident's records shall not be released to anyone outside the nursing home without the resident's approval, unless the resident transfers to another health care facility, or unless the release of the information is required by law, a third-party payment contract, or the New Jersey State Department of Health;

19. To receive and send mail in unopened envelopes, unless the resident requests otherwise. The resident also has a right to request and receive assistance in reading and writing correspondence unless it is medically contraindicated, and documented in the record by a physician;

20. To have unaccompanied access to a telephone at a reasonable hour to conduct private conversations, and, if technically feasible, to have a private telephone in his or her living quarters at the resident's own expense;

21. To stay out of bed as long as the resident desires and to be awakened for routine daily care no more than two hours before breakfast is served, unless a physician recommends otherwise and specifies the reasons in the resident's medical record;

22. To receive assistance in awakening, getting dressed, and participating in the facility's activities, unless a physician specifies reasons in the resident's medical record;

23. To meet with any visitors of the resident's choice between 8:00 A.M. and 8:00 P.M. daily. If the resident is critically ill, he or she may receive visits at any time from next of kin or a guardian, unless a physician documents that this would be harmful to the resident's health;

24. To take part in nursing home activities, and to meet with and participate in the activities of any social, religious, and community groups, as long as these activities do not disrupt the lives of other residents;

25. To leave the nursing home during the day with the approval of a physician and with the resident's whereabouts noted on a sign-out record. Arrangements may also be made with the nursing home for an absence overnight or longer;

26. To refuse to perform services for the nursing home;

27. To request visits at any time by representatives of the religion of the resident's choice and, upon the resident's request, to attend outside religious services at his or her own expense. No religious beliefs or practices shall be imposed on any resident;

28. To participate in meals, recreation, and social activities without being subjected to discrimination based on age, race, religion, sex, nationality, or disability. The resident's participation may be restricted or prohibited only upon the written recommendation of his or her physician;

29. To organize and participate in a Resident Council that presents residents' concerns to the administrator of the facility. A resident's family has the right to meet in the facility with the families of other residents in the facility;

30. To discharge himself or herself from the nursing home by presenting a release signed by the resident. If the resident is an adjudicated mental incompetent, the release must be signed by his or her next of kin or guardian;

31. To be transferred or discharged only for one or more of the following reasons, with the reason for the transfer or discharge recorded in the resident's medical record:

i. In an emergency, with notification of the resident's physician and next of kin or guardian;

ii. For medical reasons or to protect the resident's welfare or the welfare of others;

iii. To comply with clearly expressed and documented resident choice, or in conformance with the New Jersey Advance Directives for Health Care Act, as specified in N.J.A.C. 8:39–9.5(d); or

iv. For nonpayment of fees, in situations not prohibited by law.

32. To receive written notice at least 30 days in advance when the nursing home requests the resident's transfer or discharge, except in an emergency. Written notice shall include the name, address, and telephone number of the New Jersey Office of the Ombudsman for the Institutionalized Elderly, and shall also be provided to the resident's next of kin or guardian 30 days in advance;

33. To be given a written statement of all resident rights as well as any additional regulations established by the nursing home involving resident rights and responsibilities. The nursing home shall require each resident or his or her guardian to sign a copy of this document. In addition, a copy shall be posted in a conspicuous, public place in the nursing home. Copies shall also be given to the resident's next of kin and distributed to staff members. The nursing home is responsible for developing and implementing policies to protect resident rights;

34. To retain and exercise all the constitutional, civil, and legal rights to which the resident is entitled by law. The nursing home shall encourage and help each resident to exercise these rights; and

35. To voice complaints without being threatened or punished. Each resident is entitled to complain and present his or her grievances to the nursing home administrator and staff, to government agencies, and to anyone else without fear of interference, discharge, or reprisal. The nursing home is required to provide each resident and his or her next of kin or guardian with the names, addresses, and telephone numbers of the government agencies to which a resident can complain and ask questions, including the New Jersey State Department of Health and the Office of the Ombudsman for the Institutionalized Elderly. These names, addresses, and telephone numbers shall also be posted in a conspicuous place near every public telephone and on all public bulletin boards in the nursing home.

(b) Each resident, resident's next of kin, and resident's guardian shall be informed of the resident rights enumerated in this subchapter, and each shall be explained to him or her. None of these rights shall be abridged or violated by the facility or any of its staff.

Case Notes

Resident patient's next of kin lacked standing to maintain action for violation of patient's rights under former N.J.A.C. 8:30–2.4; statutory cause of action limits standing. Profeta v. Dover Christian Nursing Home, 189 N.J.Super. 83 (App.Div.1983), cert. den. 94 N.J. 576, 458 A.2d 1307 (1983).

SUBCHAPTER 5. MANDATORY ACCESS TO CARE

8:39–5.1 Mandatory admission policies and procedures

(a) The facility shall make available to indigent individuals at least five percent of its beds or, if the facility is licensed for 100 or more beds, at least 10 percent of its beds. For purposes of this section, an individual is "indigent" if he or she is an applicant for admission or a current resident of the facility, and if he or she would otherwise meet the eligibility requirements of Medicaid reimbursement or county or municipal financial assistance for nursing home care.

(b) The facility shall not deny a resident immediate readmission to the facility at the conclusion of a period of temporary discharge, if payment or reimbursement for the resident's care includes a period of temporary discharge. For purposes of this rule, a period of temporary discharge begins with a transfer to a hospital or other health facility and lasts 10 or fewer days.

(c) The facility, if it is a Medicaid provider whose Medicaid occupancy level is less than the Statewide occupancy level, shall comply with N.J.S.A. 10:5–12.2 by not denying admission to a qualified Medicaid applicant when a bed becomes available.

(d) Whenever the facility denies admission to an applicant for admission, the facility, within 14 days of the denial, shall provide written notice to the applicant or person applying on the applicant's behalf of the denial and the reason for denial.

(e) The facility shall not deny admission to any applicant for admission ("applicant for admission" means an individual who has made a formal application) based on diagnosis or health care needs if the applicant's health care needs can be reasonably accommodated and are commensurate with the services provided by a licensed long-term care facility as specified in this chapter unless:

1. The facility currently treats a high proportion of residents whose documented health problems clearly require more intensive nursing care than is ordinarily provided to most long-term care residents as measured by objective factors such as the acuity conditions enumerated at N.J.A.C. 8:39–25.2(b)2; and

2. The facility could provide health care to the applicant at an acceptable level of quality of care only by reducing the quality of care that is currently provided to other residents.

(f) The facility shall notify the Department of any intention to deny admission pursuant to (e) above to individuals who have been formally referred to the facility or have made written application for admission.

(g) A record of each completed application, including the disposition and stated reason if admission is denied, shall be kept for one year.

(h) An admission waiting list of individuals who have completed applications shall exist and shall be implemented. The facility shall have policies and procedures addressing admission priorities and retention on the waiting list, including, at a minimum, the following:

1. Dates of application; and

2. Source of payment.

Case Notes

Nursing home violated licensure requirements; refusing admission to HIV-positive patient. Department of Health v. Manheim Ave., Inc., 93 N.J.A.R.2d (HLT) 13.

8:39–5.2 Mandatory policies and procedures for access to care

(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.

(b) There shall be no discrimination against any resident or group of residents based on method of payment.

(c) The facility shall meet all currently applicable conditions attached to any Certificate of Need that has been granted to it.

(d) If a facility has reason to believe, based on a resident's behavior, that the resident poses a danger to himself or herself or others, and that the facility is not capable of providing proper care to the resident, then an evaluation should be performed in accordance with Guidelines for Inappropriate Behavior and Resident to Resident Abuse, in Appendix B.

SUBCHAPTER 6. ADVISORY ACCESS TO CARE

8:39–6.1 Advisory admission policies and procedures

(a) The waiting list of the facility incorporates a system to contact applicants or families at least quarterly, or according to an alternate schedule approved by the Department, to advise them concerning the status of the application and to inquire of the applicant's interest in remaining on the waiting list.

(b) Before admission, the resident's physician, the facility's social worker, the facility's admissions officer (if different from the social worker), and a registered professional nurse discuss the appropriateness of the placement.

(c) The facility makes available to indigent individuals at least 10 percent of its beds or, if the facility is licensed for 100 or more beds, at least 15 percent of its beds. For purposes of this subsection, an individual is "indigent" if he or she is an applicant for admission or a current resident of the facility, and if he or she would otherwise meet the eligibility requirements of Medicaid reimbursement or county or municipal financial assistance for nursing home care.

(d) The facility provides a copy of admissions policies and criteria to all applicants for admission.

SUBCHAPTER 7. MANDATORY RESIDENT ACTIVITIES

8:39–7.1 Mandatory administrative organization for resident activities

The director of resident activities shall supervise all other resident activities staff and coordinate all resident activity programs.

8:39–7.2 Mandatory staff qualifications for resident activities

(a) The facility shall have a director of resident activities who holds at least one of the following four qualifications:

1. A baccalaureate degree from an accredited college or university with a major area of concentration in recreation, creative arts therapy, therapeutic recreation, art, art education, psychology, sociology, or occupational therapy; or

2. A high school diploma and three years of experience in resident activities in a health care facility and satisfactory completion of an activities education program approved by the New Jersey State Department of Health, after a review of the specific curriculum, consisting of 90 hours of training, and incorporating the following elements:

i. Overview of the activity profession;

ii. Human development: the late adult years;

iii. Standards of practice: practitioner behavior;

iv. Activity care planning for quality of life; and

v. Methods of service delivery in the activity profession; or

3. Served as director of resident activities on June 20, 1988, and has continuously served as activities director since that time; or

4. Holds current certification from the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, 520 Stewart, Park Ridge, Illinois 60068) or the National Council for Therapeutic Recreation Certification (National Council for Therapeutic Recreation, Inc., P.O. Box 479, Thiells, NY 10984–0479).

(b) Currently employed activities directors who have completed an activities education course which was previously approved by the Department will not be required to complete the course described at (a)2 above.

8:39–7.3 Mandatory staffing amounts and availability for activities

At least 45 minutes of resident activities staff time per resident per week shall be devoted to resident activities. (This is an average. It is equal to one full-time equivalent staff member for every 53 residents.)

8:39–7.4 Mandatory resident activities services

(a) Resident activities staff shall arrange a diversity of programs to maintain residents' sense of usefulness and self-respect. Included shall be activities in each of the following categories:

1. Social (for example, parties, club meetings, picnics, and other special events);

2. Physical (for example, exercise, sports, dancing, and swimming);

3. Creative (for example, crafts, poetry, drama, music therapy, art therapy, and gardening);

4. Educational and cultural (for example, discussion groups, guest speaker programs, concerts and other forms of live entertainment, and international meals);

5. Spiritual, such as religious services;

6. Awareness, including cognitive and sensory individual and group stimulation for confused and disoriented residents; and

7. Community-integrating (for example, visits by community volunteers, visits by nursery school classes, exchange visits with other health care facilities, participation in senior citizen organization meetings or support group sessions, and participation in adopt-a-grandparent programs).

(b) If the facility requires an exception from any of the categories of activities listed at (a)1 through 7 above, reasons for the exception, such as impracticability or lack of appropriateness or interest on the part of residents, shall be documented and written documentation of the reasons for the exception shall be provided to the Department upon request.

(c) Resident activity programs shall take place in individual, small group, and large group settings.

(d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement.

(e) Residents may participate in the activities program regardless of their financial status, with the exception of special events for which there is a charge for all residents.

(f) At least weekly, a listing of all scheduled activities shall be posted in a conspicuous place in the facility.

(g) Resident activities programs shall be developed and modified on the basis of input from residents, as well as staff, family, and others.

8:39–7.5 Mandatory space and environment for resident activities

Each facility shall have an activities room that is equipped with arts and crafts supplies, games, and reading materials.

SUBCHAPTER 8. ADVISORY RESIDENT ACTIVITIES

8:39–8.1 Advisory policies and procedures for resident activities

There is a formal, continuous mechanism for activity planning, implementation and evaluation.

Case Notes

Former N.J.A.C. 3:39–1.16 required one professional nurse per unit around the clock; minimum direct nursing care standards; reimbursement denied for nursing Staff hours occasioned by erroneous reliance on non-applicable standards. In re: Preakness Hospital, 8 N.J.A.R. 389 (1982).

8:39–8.2 Advisory staff qualifications for resident activities

The director of resident activities possesses a baccalaureate degree from an accredited college or university with a major area of concentration in therapeutic recreation or creative arts therapy or holds current certification from the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, 520 Stewart, Park Ridge, Illinois 60068) or National Council for Therapeutic Recreation Certification (National Council for Therapeutic Recreation, Inc., P.O. Box 479, Thiells, NY 10984–0479).

8:39-8.3 Advisory staffing amounts and availability for resident activities

(a) At least 55 minutes of resident activities staff time per resident per week is devoted to resident activities. (This is an average. It is equal to one full-time equivalent staff member for every 44 residents.)

(b) The facility maintains an active volunteer program that includes scheduled visits to the facility on at least a weekly basis.

8:39-8.4 Advisory resident services for resident activities

(a) Resident activity programs are conducted during at least four evenings per week.

(b) Field trips are accessible for all residents who choose to participate, unless their participation would not be clinically feasible.

(c) Regularly scheduled outdoor recreation is provided.

(d) There is a pet therapy program for interested residents, with safeguards to prevent interference in the lives of other residents, and the program complies with policies and procedures developed by the facility (See Appendix A for example).

(e) The facility has an organized program for visits to residents by school or pre-school children throughout the year.

SUBCHAPTER 9. MANDATORY ADMINISTRATION

8:39-9.1 Mandatory administrative organization and responsibilities

(a) The facility shall inform the New Jersey State Department of Health of the ownership and management of the facility and its location, and proof of ownership shall be available at the facility.

1. In the case of group or corporate management of a facility, the facility shall specify:

i. Name and address of the firm or corporation; and

ii. Names and addresses of all directors of the firm or corporation.

2. Any proposed change in ownership shall conform with N.J.A.C. 8:33.

(b) The facility shall not be owned or operated by any person convicted of a crime relating adversely to the person's capability of owning or operating the facility.

(c) In a facility with more than 240 beds, in addition to the licensed administrator, there shall be a full-time administrative supervisor who is assigned the evening shift and reports directly to the licensed administrator.

(d) The administrator shall serve full-time in an administrative capacity within the facility in facilities with 100 or more beds. In facilities with fewer than 100 beds, a licensed administrator shall serve at least half-time within the facility. The administrator shall be administratively responsible for all aspects of the facility.

(e) A licensed administrator shall only be responsible for one facility, except that an administrator may be responsible for two facilities if such facilities are within a 20-mile radius and if the total number of beds for which both facilities are licensed is no more than 120.

Law Review and Journal Commentaries

Disputing Care Advance Care Directives, Robert J. Romano, Jr., 132 N.J.L.J. No. 15, S16 (1992).

8:39-9.2 Mandatory policies and procedures for administration

(a) The facility shall maintain a written record of all financial arrangements with the resident, next of kin, and/or guardian. Copies of the record shall be accessible to the resident or guardian during normal business hours or by prior arrangement.

(b) The facility shall provide the resident with 30 days prior written notice of charges, expenses, or other financial liabilities that are in addition to the agreed per diem rate. The resident's prior written approval for additional charges shall not be required in the event of a health emergency that requires the resident to receive immediate special services or supplies.

(c) Funds deposited with a facility for a particular resident's use and safekeeping shall be held in an account which is separate from any of the facility's operating accounts.

1. Funds in excess of $50.00 shall be deposited in an interest bearing account(s) and all interest earned on resident's funds shall be credited to that account.

2. If a resident's personal funds do not exceed $50.00, they shall be maintained in a separate interest bearing account, a non-interest bearing account, or a petty cash fund.

3. The facility shall assure the security of all personal funds of residents deposited with the facility, through purchase of a surety bond or an alternative which provides protection equivalent to a surety bond.

(d) Effective July 6, 1993, all residents who have advanced a security deposit to a facility prior to or upon their admission shall be entitled to receive interest earnings which accumulate on such funds or property after the effective date.

1. The facility shall hold such funds or property in trust for the resident and they shall remain the property of the resident. All such funds shall be held in an interest-bearing account as established under requirements of N.J.S.A. 30:13–1 et seq.

2. The facility may deduct an amount not to exceed one percent per annum of the amount so invested or deposited for costs of servicing and processing the accounts.

3. The facility, within 60 days of establishing an account, shall notify the resident, in writing, of the name of the bank or investment company holding the funds and the account number. The facility shall thereafter provide a quarterly statement to each resident it holds security funds in trust for, identifying the balance, interest earned, and any deductions for charges or expenses incurred in accordance with the terms of the contract or agreement of admission.

(e) The administrator shall provide to the owner and/or governing body of the facility a copy of the licensing survey report and any additional survey-related data sent by the New Jersey State Department of Health to the administrator of the facility.

(f) The following documents shall be submitted to the New Jersey State Department of Health:

1. An annual financial report or a Medicaid cost report; and

2. Statistical data, such as resident census and facility characteristics, in a format provided by the Department.

(g) The facility shall notify the New Jersey State Department of Health immediately by telephone (609) 588–7725, or (609) 392–2020 after office hours, followed within 72 hours by written confirmation, of any of the following:

1. Interruption for three or more hours of physical plant services and/or other services essential to the health and safety of residents;

2. Termination of employment of the administrator or the director of nursing, and the name and qualifications of the proposed replacement;

3. All alleged or suspected crimes which endanger the life or safety of residents or employees, which are also reportable to the police department, and which result in an immediate on-site investigation by the police.

i. In addition, the State Office of the Ombudsman for the Institutionalized Elderly shall be immediately notified of any suspected resident abuse, neglect, or exploitation of residents aged 60 or older, pursuant to P.L. 1983 c.43, N.J.S.A. 52:27G–7.1, and the Department of Health shall be immediately notified for residents under the age of 60; and

4. All fires, disasters, deaths, and imminent dangers to a resident's life or health resulting from accidents or incidents in the facility.

(h) The facility shall investigate every reported case of misappropriated property.

(i) When a vacancy exists in the position of administrator for 48 hours or more, the facility shall arrange for licensed administrative supervision on a consultant basis, which shall continue until a new licensed administrator shall be appointed, which shall be within 90 days of the appointment of the consultant.

(j) The facility shall make all policy and procedure manuals available to residents, families, and guardians during normal business hours or by prior arrangement.

(k) Results of the most recent licensure survey and Federal Standard Certification conducted by the New Jersey State Department of Health shall be available for inspection by any resident or visitor, in a readily accessible place, at all times. A notice announcing the availability of those results and all other surveys conducted in the past 12 months shall be conspicuously posted in diverse readily accessible areas of the facility.

(*l*) A facility shall notify the Department of Health, Division of Health Facilities Evaluation and the Division of Medical Assistance and Health Services, Department of Human Services, if it is a participating Medicaid provider, immediately in writing at such time as it becomes financially insolvent and upon the filing of a voluntary or involuntary petition for bankruptcy under Title 11 of the United States Code. Insolvency means that the sum of the facility's debts is greater than the value of all of its assets, that the facility defaults on the primary debt on the property, or that in any month the current ratio falls below 1.0, or that the average payment period ratio for current liabilities exceeds 150 days. Facilities which are in the first 12 months of operation from the date of initial licensure are exempt from reporting a condition of insolvency to the Department. All notification of insolvency or a bankruptcy filing, when received by the Department of Health or the Department of Human Services, shall be kept confidential from the public and any other organization unless express authorization to do so has been provided by the facility.

(m) No resident shall be discharged between 5:00 P.M. and 8:00 A.M., except in an emergency or with the consent of the resident and family or responsible person.

(n) Policies for transfer shall include method of transportation, a transfer form that is consistent with "Hospital and Nursing Home Patient Transfer Form and Plan of Care" in Appendix B, incorporated herein by reference, copies of relevant medical records, including assessments (MDS; PASSAR) and advance directives if applicable, to accompany or follow the resident, procedures for security of the resident and his or her personal effects, and timeliness of transfer.

8:39–9.3 Mandatory staff qualifications

(a) The facility shall be directed by an individual who holds a current New Jersey license as a nursing home administrator.

(b) A nursing home administrator whose license is either suspended or revoked, pursuant to N.J.S.A. 25:2H–27 and 26:2H–28 (P.L. 1968, c.356) shall not be appointed or retained in the facility in any administrative, managerial, supervisory, or similar position.

(c) All personnel who require licensure, certification or authorization in order to provide resident care shall be licensed, certified or authorized under applicable laws and regulations of the State of New Jersey. The licenses, certifications or authorizations shall be verified by the facility.

(d) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental health, emotionally stable, of good moral character, are concerned for the safety and well-being of residents; and have not been convicted of a crime relating adversely to the person's ability to provide resident care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.)

(e) The facility shall ensure that all private duty nursing staff and contract personnel are monitored and those who do not meet the requirements at (d)1 and 2 above or facility policies and procedures are not permitted to perform services in the facility.

(f) There shall be written policies and procedures for personnel that are reviewed annually, revised as needed, and implemented. They shall include at least:

1. A written job description for each category of personnel in the facility and distribution of a copy to each newly hired employee;

2. Personnel policies in compliance with Federal and State requirements;

3. A system to ensure that written, job-relevant criteria are used in making evaluation, hiring, and promotion decisions;

4. A system to ensure that employees meet ongoing requirements for credentials; and

5. Written criteria for personnel actions that require disciplinary action.

(g) The facility shall develop and implement a grievance procedure for all staff. The procedure shall include, at least, a system for receiving grievances, a specified response time, assurance that grievances are referred appropriately for review, development of resolutions, and follow-up action.

(h) Personnel records shall be confidential and accessible only to authorized personnel.

(i) Each staff member shall wear clean clothes and shall use good personal hygiene.

8:39–9.4 Staffing amounts and availability

The administrator or an alternate designated by the administrator shall be on the premises at all times to direct operations.

8:39–9.5 Mandatory policies and procedures for advance directives

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

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

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

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

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

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

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

(h) The facility shall develop and implement policies and procedures for the declaration of death of residents, in instances where applicable, in accordance with N.J.S.A. 26:6–1 et seq. and the New Jersey Declaration of Death Act, N.J.S.A. 26:6A–1 et seq. (P.L. 1991, c.90). Such policies shall also be in conformance with rules promulgated by the New Jersey Board of Medical Examiners which address declaration of death based on neurological criteria (N.J.A.C. 13:35–6A), including the qualifications of physicians authorized to declare death based on neurological criteria and the acceptable medical criteria, tests, and procedures which may be used. The policies and procedures shall also accommodate a resident's religious beliefs with respect to declaration of death.

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

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

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

SUBCHAPTER 10. ADVISORY ADMINISTRATION

8:39–10.1 Advisory policies and procedures for administration

(a) The administrator monitors trends in staff turnover.

(b) Each of at least five service directors participates in facility planning through preparation of annual budgets and annual reports, and participates in annual budget conferences among all service directors and the administrators.

8:39–10.2 Advisory staff qualifications

The administrator holds current professional certification from the American College of Health Care Administrators, or possesses a master's degree in health care administration or a related field.

8:39–10.3 Advisory staff education and training

(a) Personnel who provide direct resident care are offered an opportunity to attend at least one education program each year and receive fee reimbursement or compensatory time off. Records of continuing education programs attended are maintained.

(b) The facility conducts a tuition aid program directed toward the career development and upward mobility of staff, including both professional and ancillary personnel.

(c) The facility is a teaching nursing home, that is, the site of an internship, externship, or residency training program for health professionals, as part of the curriculum of an accredited or State-approved school or training program. The facility has sought input from the residents and/or the resident council concerning teaching programs.

(d) The facility maintains a library of textbooks and/or recent periodicals on long-term care, geriatric care, nursing, and other disciplines that is accessible to staff.

SUBCHAPTER 11. MANDATORY RESIDENT ASSESSMENT AND CARE PLANS

8:39–11.1 Mandatory completion of resident assessment and coordination of care plans

A registered professional nurse (RN) shall assess the nursing needs of each resident, coordinate the written interdisciplinary care plan, and ensure the timeliness of all services.

8:39–11.2 Mandatory policies and procedures for resident assessment and care plans

(a) A physician shall provide orders for each resident's care beginning on the day of admission.

(b) Each physician order shall be executed by the nursing, dietary, social work, activities, rehabilitation or pharmacy service, as appropriate in accordance with professional standards of practice.

(c) Each resident shall be examined by a physician within five days before, or 48 hours after, admission.

(d) An initial assessment and care plan shall be developed on the day of admission and include at least personal hygiene, immediate dietary needs, medications, and ambulation.

(e) A comprehensive assessment shall be completed for each resident within 14 days of admission, utilizing the Standardized Resident Assessment Instrument (Minimum Data Set) (see Appendix D, incorporated herein by reference) as specified by the Department, or on an equivalent assessment instrument which has been developed by the facility. The complete assessment and care plan shall be based on oral or written communication and assessments provided by nursing, dietary, resident activities, and social work staff; and when ordered by the physician, assessments shall also be provided by other health professionals. The care plan shall include measurable objectives with interventions based on the resident's care needs and means of achieving each goal.

(f) The complete care plan shall be established and implementation shall begin within 21 days, and shall include, if appropriate, rehabilitative/restorative measures, preventive intervention, and training and teaching of self-care.

(g) If a resident is discharged to a hospital and returns to the facility within 30 days of discharge, reassessment shall be conducted in those areas where the resident's needs have changed substantially. A complete reassessment shall be performed if the resident was discharged for more than 30 days.

(h) There shall be a scheduled comprehensive reassessment in each service involved in the initial assessment, plus other areas which the physician or interdisciplinary team indicates are necessary. Reassessments shall be performed according to time frames established in the previous care plan.

(i) A reassessment shall be performed in response to all substantial changes in the resident's condition, such as fractures, onset of debilitating chronic diseases, loss of a loved one, or recovery from depression.

(j) The facility shall have a written transfer agreement with one or more hospitals for emergency care and inpatient and outpatient services.

8:39–11.3 Mandatory resident services for discharge and transfer

(a) Discharge plans, for those residents considered to be likely candidates for discharge into the community or a less intensive care setting, shall be developed by the interdisciplinary team prior to discharge and shall reflect physician's orders, and communication with the resident and the resident's family.

(b) The facility shall arrange for transfer of residents to other health care facilities, and to health care services provided outside the long-term care facility, in accordance with the physician's orders.

SUBCHAPTER 12. ADVISORY RESIDENT ASSESSMENT AND CARE PLANS

8:39–12.1 Advisory policies and procedures for resident assessment and care plan

(a) The resident care plan is developed at a meeting held by an interdisciplinary team that includes professional and/or ancillary staff from each service providing care to the resident.

(b) The facility makes care planning meetings available at mutually agreeable times, including evenings and weekends, for the convenience of families and significant others.

8:39–12.2 Advisory resident services for off-site services

The facility provides and/or arranges for someone to accompany each resident to scheduled visits to off-site health care services.

SUBCHAPTER 13. MANDATORY COMMUNICATION

8:39–13.1 Mandatory communication policies and procedures

(a) Each service shall maintain a current manual of policies and procedures for providing services.

(b) The administrative staff shall retain a written current manual of policies and procedures for the facility as a whole and for each individual service.

(c) The facility shall notify any family promptly of an emergency affecting the health or safety of a resident.

(d) The facility shall notify the attending physician promptly of substantial changes in the resident's medical condition.

8:39–13.2 Mandatory resident communication services

(a) Residents and their families shall be given the opportunity to participate in the development and implementation of the care plan, and their involvement shall be documented in the resident's medical record.

(b) Before or on the day of admission, residents and families shall be informed in writing about services provided by the facility, charges imposed for services at the facility, the availability of financial assistance, the rights and responsibilities of residents and families, and the role of each service on the health care team; and they shall be given a tour of resident care units in the facility.

(c) When a resident or family group exists, the facility shall listen to the views and act upon or respond to the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

8:39–13.3 Mandatory staff communication qualifications

(a) Staff shall always communicate with residents and families in a respectful way, and shall introduce and identify themselves to residents as required and necessary.

(b) The facility shall ensure that all staff including staff members not fluent in English are able to communicate effectively with residents and families.

8:39–13.4 Mandatory staff education and training for communication

(a) Each service shall conduct an orientation program for new employees of that service unless the orientation program is conducted by the administrator or a qualified designee.

1. For purposes of complying with this requirement, "new employees" shall be defined to include all permanent and temporary resident care personnel, nurses retained through an outside agency, and persons providing services by contract.

2. The orientation program shall begin on the first day of employment.

3. The orientation program for all staff shall include orientation to the facility and the service in which the individual will be employed, at least a partial tour of the facility, a review of policies and procedures, identification of individuals to be contacted under specified circumstances, and procedures to be followed in case of emergency.

(b) Each service shall provide education or training for all employees in the service at least four times per year and in response to resident care problems, implementation of new procedures, technological developments, changes in regulatory standards, and staff member suggestions. All staff members shall receive training at least two times per year about the facility's infection control procedures, including handwashing and personal hygiene requirements.

(c) At least one education training program each year shall be held for all employees on each of the following topics:

1. Procedures to follow in case of emergency;
2. Resident rights; and
3. Pharmacy (for all direct care staff).

(d) All nursing and professional staff of the facility shall receive orientation and annual training in the use of restraints, including at least:

1. Policies and procedures in accordance with N.J.A.C. 8:39–27.2;
2. Emergency and non-emergency procedures;
3. Practice in the application of restraints and alternative methods of intervention; and
4. Interventions by licensed and non-licensed nursing personnel.

(e) At least one education or training program each year shall be held for all administrative and resident care staff regarding the rights and responsibilities of staff under the New Jersey Advance Directives for Health Care Act (P.L. 1991, c.201) and the Federal Patient Self Determination Act (P.L. 101–508), and internal facility policies and procedures to implement these laws.

(f) The facility shall maintain attendance lists for all education or training programs conducted in, or sponsored by, the facility.

SUBCHAPTER 14. ADVISORY COMMUNICATION

8:39–14.1 Advisory resident services

(a) The facility has one or more wellness programs open to the public, such as programs to reduce or prevent smoking, alcohol and drug abuse, elder abuse, obesity, or hypertension.

(b) Periodic meetings are open to all staff, residents, and families to discuss any problems, encourage the resident to reach his or her potential, examine the goals and expectations of different individuals, describe how questions and complaints can be presented, and review the concept of interdisciplinary care.

(c) Provision is made for residents to retain membership, join, and/or participate in community activities. These should include organizations, community projects, holiday observances, or charitable events.

(d) A facility newsletter is provided to residents and families at least quarterly.

(e) Each staff member wears an easily readable name tag.

8:39–14.2 Advisory staff education and training for communication

(a) Periodic meetings are held with each service to discuss ways to improve care of all residents.

(b) Education and training of staff includes an accredited program in cardiopulmonary resuscitation (CPR) which offers staff an opportunity to be recertified on an annual basis.

(c) Each service establishes and implements education or training programs for members of other services on diverse topics.

(d) Education or training sessions are offered which address new concepts and directions in cultural and interpersonal concepts.

SUBCHAPTER 15. MANDATORY DENTAL SERVICES

8:39–15.1 Mandatory resident dental services

(a) The facility shall provide or arrange emergency dental care to relieve pain and infection.

(b) The facility shall assist interested residents in making arrangements to receive dental examinations, routine prophylaxis, and care.

(c) The facility shall ensure that arrangements are made to transport residents for routine and emergency dental care.

(d) All resident dentures shall be labeled.

SUBCHAPTER 16. ADVISORY DENTAL SERVICES

8:39–16.1 Advisory resident dental services

(a) The facility provides in-house dental services, including treatment and prophylactic care.

(b) The facility follows established protocols for providing all residents with regularly scheduled routine prophylactic dental services and treatments when indicated, delivered by a dentist or a dental hygienist, except for residents whose medical records contain an explanation of why such services would not benefit the resident.

SUBCHAPTER 17. MANDATORY DIETARY SERVICES

8:39–17.1 Mandatory structural organization for dietary services

(a) The facility shall designate a food service director who, if not a dietitian, functions with scheduled consultation from a dietitian. The food service director shall be responsible for the direction, provision, and quality of dietary services.

(b) Menus shall be planned and scheduled by the food service director or the dietitian, and shall be approved by the dietitian at least 14 days in advance.

(c) The dietitian shall perform the dietary assessment and reassessment, which shall include examination of and communication with the resident if the resident's condition permits.

(d) Services that are provided by a food service company shall be covered by a written contract.

8:39–17.2 Mandatory policies and procedures for dietary services

(a) The facility shall make available a current dietary manual which shall have been approved by the dietitian and

the medical director. The facility shall serve diets which are consistent with the dietary manual.

(b) The facility shall post current menus with portion sizes in the food preparation area. The facility shall keep menus for 30 days with any changes accurately recorded.

(c) The facility shall designate responsibility for observation and documentation of meals refused or missed by a resident and of any resident who requires assistance with meals.

(d) A dietitian shall adhere to an established system of nutritional assessment, which shall include examination of and communication with the resident if the resident's condition permits.

(e) The facility shall routinely provide nondisposable dishes and cutlery at all meals except for special meal activities or individual resident needs.

(f) Meals shall be scheduled in such a way that no more than 14 hours elapse between a substantial evening meal and breakfast the next morning and that the first meal shall not be served before 7:00 A.M. unless requested by the resident.

1. Up to 16 hours may elapse between a substantial evening meal and breakfast the following day if the following conditions are met:

i. A resident group agrees to this meal span; and

ii. A nourishing bedtime snack is served.

(g) All food service facilities shall operate with safe food handling practices in accordance with Chapter XII of the New Jersey Sanitary Code, N.J.A.C. 8:24.

8:39–17.3 Mandatory staff qualifications for dietary services

(a) The dietitian shall possess a bachelor's degree from an accredited college or university with a major area of concentration in a nutrition-related field of study, and one year of full-time professional experience or graduate-level training in nutrition.

(b) There shall be a full-time food service director or manager who has met the requirements of a dietitian, or has graduated from a New Jersey State-approved course in food service management or its equivalent.

8:39–17.4 Mandatory staffing amounts and availability for dietary services

(a) The dietitian shall spend an average of 15 minutes per resident each month providing dietary services in the facility. (This is an average. It is equal to one full-time equivalent dietitian for every 693 residents.)

(b) Dietary service personnel shall be present for a period of at least 12 hours each day.

8:39–17.5 Mandatory resident dietary services

(a) Each resident shall receive a diet which:

1. Corresponds to the physician's order, the dietitian's instructions, and resident's food preferences;

2. Is served in the proper consistency and at the proper temperature; and

3. Provides nutrients and calories based upon current recommended dietary allowances of the National Academy of Sciences, adjusted for the resident's age, sex, weight, physical activity, physiological function, and therapeutic needs.

(b) The facility shall provide between-meal and bedtime nourishment, and beverages shall be available at all times for each resident unless contraindicated by a physician, as documented in the resident's medical record.

(c) The facility shall offer substitute foods and beverages to all residents who refuse the food served at meal times. Such substitutes shall be of equivalent nutritional value and planned in advance in writing.

(d) No resident shall have to wait for assistance in eating for more than 15 minutes following delivery of a tray to the resident.

(e) The facility shall select foods and beverages, which include fresh and seasonal foods, and shall prepare menus with regard to the nutritional and therapeutic needs, cultural backgrounds, food habits, and personal preference of residents.

SUBCHAPTER 18. ADVISORY DIETARY SERVICES

8:39–18.1 Advisory structural organization for dietary services

A registered dietitian performs the resident dietary assessment and participates in the interdisciplinary plan of care.

8:39–18.2 Advisory staff qualifications for dietary services

The director of dietary services or the dietitian is registered by the Commission on Dietetic Registration of the American Dietetic Association (R.D.).

8:39–18.3 Advisory staffing amounts and availability for dietary services

The dietitian spends an average of 20 minutes per resident each month providing dietary services in the facility. (This is an average. It is equal to one full-time equivalent dietitian for every 520 residents.)

8:39–18.4 Advisory resident dietary services

(a) There are dietary observances for national and/or religious holidays.

(b) Fresh fruits and vegetables are served in season on a daily basis.

(c) The facility utilizes a dining room/area, other than day rooms, for residents with special needs.

(d) Residents have access to a refrigerator or snack bar.

(e) Residents are offered a selective menu consisting of at least three main entrees at each meal.

(f) A menu committee composed of residents participates in meal planning.

(g) The facility sponsors a guest meal program.

8:39–18.5 Supplies and equipment

The facility provides cloth table covers and cloth napkins at least once a day.

SUBCHAPTER 19. MANDATORY INFECTION CONTROL AND SANITATION

8:39–19.1 Mandatory organization for infection control and sanitation

(a) The facility shall have an infection prevention and control program conducted by an infection control committee which shall include representatives from at least administrative, nursing, medical, dietary, housekeeping or environmental services, and pharmacy staffs. The infection control committee shall review all infection control policies and procedures, periodically review infection control surveillance data, and formulate recommendations to the administrator regarding infection control activities.

(b) Responsibility for the infection prevention and control program shall be assigned to an employee who is designated as the infection control coordinator, with education, training, completed course work, or experience in infection control or epidemiology; or services shall be provided by contract. If the services are provided by contract, the facility shall designate an on-site employee to implement, coordinate, and ensure compliance with infection control policies and procedures.

8:39–19.2 Mandatory employee health policies and procedures for infection control and sanitation

(a) Employees who have signs or symptoms of a communicable disease shall not be permitted to perform functions that expose residents to risk of transmission of the disease.

(b) If a communicable disease prevents the employee from working, a physician's statement approving the employee's return shall be required. Prior to the employee's return to work, the physician's statement shall be reviewed by the administrator or the administrator's designee. If the employee has been absent for no longer than three days, the employee's return to work may be approved by the nursing director or the infection control committee, following assessment by the nurse.

(c) The facility shall develop and implement procedures for the care of employees who become ill while at work or who have a work-related accident.

8:39–19.3 Mandatory waste removal policies and procedures

(a) Regulated medical waste shall be collected, stored, handled, and disposed of in accordance with applicable Federal laws and regulations, and the facility shall comply with the provisions of N.J.S.A. 13:1F–48.1 et seq., the Comprehensive Regulated Medical Waste Management Act, and all rules promulgated pursuant to the aforementioned Act.

(b) The infection control committee shall develop and implement written policies and procedures for collection, storage, handling, and disposal of all solid waste that is not regulated medical waste.

(c) All solid waste that is not regulated medical waste shall be disposed of in a sanitary landfill or other manner approved by the Department of Environmental Protection and Energy. Disposal shall be as frequent as necessary to avoid creating a nuisance.

8:39–19.4 Mandatory general policies and procedures for infection control and sanitation

(a) The facility shall develop, implement, comply with, and review, at least annually, written policies and procedures regarding infection prevention and control which are consistent with the most up-to-date Centers for Disease Control and Prevention publications, including, but not limited to, the following:

1. Guidelines for Handwashing and Hospital Environmental Control;

2. Guidelines for Isolation Precautions in Hospitals;

3. Prevention and Control of Tuberculosis in Facilities Providing Long-term Care to the Elderly;

4. Prevention of Nosocomial Pneumonia;

5. Prevention of Catheter Associated Urinary Tract Infections; and

6. Prevention of Intravascular Infections.

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

National Technical Information Service
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161

or

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

(b) The facility shall comply with applicable current Occupational Safety and Health Administration (OSHA) requirements.

(c) The infection control coordinator shall provide continuous collection and analysis of data, including determination of nosocomial infections, epidemics, clusters of infections, infections due to unusual pathogens or multiple antibiotic resistant bacteria, and any occurrence of nosocomial infection that exceeds the usual baseline levels.

(d) The infection control coordinator shall make recommendations for corrective actions based on surveillance and data analysis.

(e) The facility shall have a system for investigating, evaluating, and reporting the occurrence of all reportable infections and diseases as specified in Chapter II of the State Sanitary Code (N.J.A.C. 8:57–1.1 through 1.12).

(f) The facility shall maintain listings of all residents and personnel who have reportable infections, diseases, or conditions.

(g) The facility shall implement a policy for tuberculosis screening of all residents which begins prior to admission and concludes within 30 days following admission. If the admission screening is conducted through chest X-ray within three months prior to admission, the resident shall receive a two-step Mantoux skin test within three months after admission.

(h) If used, all reusable respiratory therapy equipment and instruments that touch mucous membranes shall be disinfected or sterilized in accordance with the Centers for Disease Control and Prevention publication "Guidelines for Handwashing and Hospital Environmental Control," incorporated herein by reference, and with manufacturer's recommendations.

(i) Disinfection procedures for items that come in contact with bed pans, sinks, and toilets shall conform with established protocols for cleaning and disinfection, in accordance with the Centers for Disease Control publication "Guidelines for Handwashing and Hospital Environmental Control," incorporated herein by reference, and with manufacturer's recommendations. All resident care items shall be cleaned, disinfected, or sterilized, according to the use of the item.

(j) All residents shall be provided with an opportunity to wash their hands before each meal and shall be encouraged to do so. Staff shall wash their hands before each meal and before assisting residents in eating. Handwashing practices shall be monitored at least monthly by the infection control coordinator.

(k) Personnel shall wash their hands with soap and warm water for between 10 and 30 seconds or use other effective hand sanitation techniques immediately prior to contact with residents.

8:39–19.5 Mandatory staff qualifications; health history and examinations

(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or NP/CNS, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment upon employment, the physician's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.

(b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows:

1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.

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

3. Any employee with positive results shall be referred to the employee's personal physician and if active tuberculosis is suspected or diagnosed shall be excluded from work until the physician provides written approval to return.

(c) The facility shall have written policies and procedures requiring annual Mantoux tuberculin skin tests for all employees, except those exempted under (b) above.

(d) The facility shall assure that all current employees who have not received the two-step Mantoux test upon employment, except those exempted by (b) above, shall receive a test by February 21, 1995. The facility shall act on the results of tests of current employees in the same manner as prescribed in (b) above.

(e) The facility shall report at least semi-annually the results of all tuberculin testing of personnel to the Department of Health, Division of Epidemiology, Tuberculosis Program, on forms provided by the Department.

(f) Yearly influenza immunization shall be offered to employees at no charge.

8:39–19.6 Mandatory space and environment for water supply

(a) The water supply used for drinking or culinary purposes shall be adequate in quantity, of a safe sanitary quality, and from a water system which shall be constructed, protected, operated, and maintained in conformance with the New Jersey Safe Drinking Water Act, N.J.S.A. 58:12A–1 et seq. and N.J.A.C. 7:10 and local laws, ordinances, and regulations. Copies of the Safe Drinking Water Act can be obtained from the Department of Environmental Protection, Bureau of Potable Water, CN 209, Trenton, New Jersey 08625.

(b) There shall be no cross connections between city and well water supplies. When the facility uses well water for potable water every day, a double check valve shall be permitted if the facility has approval for such use from the water company and the New Jersey State Department of Environmental Protection.

(c) Equipment requiring water drainage, such as ice machines and water fountains, shall be properly drained to a sanitary connection.

(d) Hot (95 to 110 degrees Fahrenheit) and cold running water shall be provided. Hot water in resident areas shall not exceed 110 degrees Fahrenheit.

8:39–19.7 Mandatory space and environment for sanitation and waste management

(a) Solid waste shall be stored in clean, solidly constructed containers with tight-fitting lids for the storage of solid wastes.

(b) Storage areas for solid waste containers shall be kept clean. Waste shall be collected from all storage areas regularly to prevent nuisances such as odors, flies, or rodents.

(c) There shall be no back siphonage conditions present.

(d) All food service facilities shall be maintained in conformance with Chapter XII of the New Jersey State Sanitary Code, N.J.A.C. 8:24.

(e) If the facility has an incinerator, it shall operate with the necessary permits from the New Jersey Department of Environmental Protection and Energy and shall not create a nuisance to the facility or the community.

(f) Solid waste which is not regulated medical waste shall be stored within the containers provided for it outside the facility or in a separate room that is maintained in a clean and sanitary condition. Waste shall be collected from the storage room regularly to prevent nuisances such as odors, flies, or rodents, and so that the waste shall not overflow or accumulate beyond the capacity of the storage containers.

(g) Garbage compactors shall be located on an impervious pad that is graded to a drain. For new construction, the drain shall be connected to the sanitary sewage disposal system.

(h) Plastic bags shall be used for solid waste removal from resident care units and supporting departments. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal.

8:39–19.8 Mandatory supplies and equipment for infection control and sanitation

(a) The sewage disposal system shall be maintained in good repair and operated in compliance with state and local laws, ordinances, and regulations.

(b) Water piping carrying non-potable water shall be clearly labeled.

(c) Commercial sterile supplies shall be used in accordance with manufacturers' recommendations, and before expiration dates, and packages shall be inspected to ensure integrity.

(d) Bed pan washers shall be in good working order and properly maintained.

(e) Toilet tissue and proper waste receptacles shall be provided.

(f) Suitable hand cleanser and sanitary towels or approved hand-drying machines shall be provided.

(g) Equipment and supplies used for sterilization, disinfection, and decontamination purposes shall be maintained according to manufacturers' specifications.

SUBCHAPTER 20. ADVISORY INFECTION CONTROL AND SANITATION

8:39–20.1 Advisory policies and procedures for infection control

(a) The facility routinely offers Hepatitis B vaccine to all employees, regardless of risk status or duties, without charge.

(b) Employees undergo periodic or annual health screening.

(c) The facility maintains records documenting contagious diseases contracted by employees during employment.

8:39–20.2 Advisory staff qualifications

(a) The infection control coordinator is certified in Infection Control (CIC) by the National Board of Infection Control, P.O. Box 14661, Lenexa, KS 66286–4661.

(b) The infection control coordinator is an active member of the National Association for Practitioners in Infection Control and Epidemiology, Inc. (APIC), 1016 Sixteenth Street NW, Sixth Floor, Washington, DC 20036.

(c) The infection control coordinator has completed an APIC Basic Training Course or has received at least 25 hours of training in infection control, and receives an additional six hours of training annually.

8:39–20.3 Advisory staff education and training for infection control

At least four education or training programs on infection control are held every year so that all staff members are fully informed about infection control requirements that apply to them.

SUBCHAPTER 21. MANDATORY LAUNDRY SERVICES

8:39–21.1 Mandatory laundry policies and procedures

(a) Soiled laundry shall be stored in a ventilated area, separate from other supplies, and shall be stored, sorted, rinsed, and laundered only in areas specifically designated for those purposes.

(b) All soiled laundry from resident rooms and other service units shall be stored, transported, collected, and delivered in a covered laundry bag or cart. Laundry carts shall be in good repair, kept clean, and identified for use with either clean or soiled laundry.

(c) Soiled laundry contaminated with blood and/or body fluids shall be collected in an effectively closed leakproof bag of sufficient strength to safely contain such laundry from point of origin to point of processing.

(d) Clean laundry shall be protected from contamination during processing, storage, and transportation within the facility.

(e) Soiled and clean laundry shall be kept separate.

(f) An established protocol, reviewed by the infection control committee, shall be followed to reduce the number of bacteria in the fabrics.

(g) Equipment surfaces that come into contact with laundry shall be sanitized.

(h) The facility shall develop and implement policies and procedures, reviewed by the infection control committee, to protect staff from contamination when handling soiled laundry.

(i) Sour testing to ensure neutralization of alkaline residues from built detergents shall be conducted, and fabric pH shall be maintained at 7.0 or below after souring.

(j) The facility shall develop and implement policies and procedures to ensure that residents' personal clothing is collected, processed and returned to the resident in a sanitary manner and in good condition.

(k) The facility shall have a system to identify each resident's clothing and a procedure to locate and/or minimize loss of clothing.

8:39–21.2 Mandatory space and environment for laundry facilities

If the facility has an on-premises laundry, it shall provide a receiving, holding, and sorting area with hand-washing facilities. The walls, floors, and ceilings of the area shall be clean and in good repair. The flow of ventilating air shall be from clean to soiled areas, and ventilation shall be adequate to prevent heat and odor build-up.

8:39–21.3 Mandatory supplies and equipment for laundry

(a) The facility shall have a supply of linen appropriate to the resident's needs that is clean, in good repair, and is at least three times the number of residents.

(b) The facility shall have a supply of blankets that is at least two times the number of residents.

8:39–21.4 Mandatory quality assurance for laundry

All facilities, including those which contract with a commercial laundry service, shall evaluate the service as part of the quality assurance program.

SUBCHAPTER 22. ADVISORY LAUNDRY SERVICES (RESERVED)

SUBCHAPTER 23. MANDATORY MEDICAL SERVICES

8:39–23.1 Mandatory structural organization for medical services

(a) Each facility shall have a medical director who is currently licensed to practice medicine by the New Jersey State Board of Medical Examiners.

1. The medical director shall coordinate medical care and direct the administrative aspects of medical care in the facility.

2. The medical director shall approve all medical care policies and procedures. These policies and procedures shall be followed.

3. The medical director shall participate in the facility's quality assurance program through meetings, interviews, and/or preparation or review of reports.

4. The medical director shall be an active participant on the facility's infection control committee, pharmacy and therapeutics committee, and a committee that is responsible for developing policies and procedures for resident care.

(b) Facilities with fewer than 60 beds may develop an alternate system of medical direction, if the facility can document that medical staff perform the requirements at (a)1 through 4 above.

Case Notes

Nursing home did not violate Conscientious Employee Protection Act by discharging physician. Fineman v. New Jersey Dept. of Human Services, 272 N.J.Super. 606, 640 A.2d 1161 (A.D.1994), certification denied 138 N.J. 267, 649 A.2d 1287.

8:39–23.2 Mandatory resident care policies

(a) The medical director shall ensure that for each resident there is a designated primary and an alternate physician who can be contacted when necessary.

(b) Each physician order shall be properly entered into the resident's medical record.

(c) Each resident's attending physician shall review the resident's medical record on a scheduled basis to ensure that care plans and medical orders are properly followed.

(d) The facility shall maintain a list of consultant physicians who are available for referrals made by the attending physician and shall make arrangements for referrals to psychological services.

(e) The medical director shall review all reports of incidents which have been documented in accordance with N.J.A.C. 8:39–9.2(g)4 and 33.1(d).

(f) The medical director, or physicians designated by the medical director, shall respond quickly and effectively to medical emergencies which are not handled by another attending physician, including in-patient admissions.

(g) A physician shall visit each resident at least every 30 days unless the medical record contains an explicit justification for not doing so. Following the initial visit, alternate 30 day visits may be delegated to a nurse practitioner or clinical nurse specialist, certified in accordance with The Nurse Practitioner/Clinical Nurse Specialist Certification Act (P.L. 1991, c.377), and as regulated by the New Jersey State Board of Nursing statutes (N.J.S.A. 45:11–23 et seq.) and regulations (N.J.A.C. 13:37), or to a New Jersey licensed physician assistant, in accordance with facility policies.

Law Review and Journal Commentaries

Retaliatory Termination—Physicians. Steven P. Bann, 137 N.J.L.J. No. 5, 61 (1994).

Case Notes

Nursing home did not violate Conscientious Employee Protection Act by discharging physician. Fineman v. New Jersey Dept. of Human Services, 272 N.J.Super. 606, 640 A.2d 1161 (A.D.1994), certification denied 138 N.J. 267, 649 A.2d 1287.

SUBCHAPTER 24. ADVISORY MEDICAL SERVICES

8:39–24.1 Advisory medical staff qualifications

The medical director is board-certified in a primary care specialty, such as family medicine, gerontology, or general internal medicine.

8:39–24.2 Advisory resident medical services

(a) The facility arranges for physician visits in the facility on a scheduled appointment basis in an office provided for that purpose.

(b) The facility has a staff or consultant psychiatrist with admitting privileges to the inpatient psychiatric unit at a hospital.

SUBCHAPTER 25. MANDATORY NURSE STAFFING

8:39–25.1 Mandatory policies and procedures for nurse staffing

(a) There shall be a full-time director of nursing or nursing administrator who is a registered professional nurse

licensed in the State of New Jersey, who has at least two years of supervisory experience in providing care to long-term care residents, and who supervises all nursing personnel.

(b) During a temporary absence of the director of nursing, there shall be a registered professional nurse on duty who shall be designated in writing as an alternate to the director of nursing. The alternate shall be temporarily responsible for supervising all nursing personnel.

8:39–25.2 Mandatory nurse staffing amounts and availability

(a) The facility shall provide nursing services and licensed nursing and ancillary personnel at all times. In accordance with N.J.A.C. 13:37–6.2, the registered professional nurse may delegate selected nursing tasks in the implementation of the nursing regimen to licensed practical nurses and ancillary nursing personnel.

(b) Registered professional nurses, licensed practical nurses, and nurse aides shall spend the following amounts of time on professional duties (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities providing more than the minimum hours required at N.J.A.C. 8:39–25.1(a) above):

1. Total number of residents multiplied by 2.5 hours/day; plus

2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:

Tracheostomy	1.25 hours/day
Use of respirator	1.25 hours/day
Head trauma stimulation/ advanced neuromuscular/ orthopedic care	1.50 hours/day
Intravenous therapy	1.50 hours/day
Wound care	0.75 hour/day
Oxygen therapy	0.75 hour/day
Nasogastric tube feedings and/or gastrostomy	1.00 hour/day

(c) In facilities with 150 licensed beds or more, there shall be an assistant director of nursing who is a registered professional nurse.

(d) There shall be visual observation by a member of the resident care staff of each resident at least once per hour. These observations need not be documented.

(e) A registered professional nurse shall be on duty at all times in facilities with more than 150 licensed beds.

(f) At least 20 percent of the hours of care required by (b) above shall be provided by individuals who are either registered professional nurses or licensed practical nurses.

(g) The nurse aide component of the facility's total hourly nurse staffing requirement, as specified in (b) above, shall be met by nurse aides who have completed a nurse aide training course approved by the New Jersey State Department of Health and have passed the New Jersey Aide Certification Examination, in accordance with N.J.A.C. 8:39–43.

Case Notes

State's Medicaid reimbursement plan was not shown to be inadequate to provide recipients with nursing care required by federal law. New Jersey Ass'n of Health Care Facilities, Inc. v. Gibbs, D.N.J.1993, 838 F.Supp. 881.

State substantially complied with procedural requirements for computing Medicaid reimbursement rates for nursing facilities. New Jersey Ass'n of Health Care Facilities, Inc. v. Gibbs, D.N.J.1993, 838 F.Supp. 881.

8:39–25.3 Mandatory nursing staff qualifications

(a) There shall be at least one registered professional nurse on duty in the facility during all day shifts. (During a temporary absence, not to exceed 72 hours, the registered professional nurse may be on duty during the evening or night shift).

(b) There shall be at least one registered professional nurse on duty or on call during all evening and night shifts.

8:39–25.4 Mandatory nursing staff education and training

(a) A program shall be established and implemented for individualized orientation of nurse aides, including resident care problem simulations, training and demonstrations in basic nursing skills, and an internship of two to five days, depending on experience.

(b) Each nurse aide shall receive, at a minimum, 12 hours of regular in-service education per year, the content of which shall be based on the outcome of performance reviews of every nurse aide which are completed at least once every 12 months. (The 12 hours may include topics included in OBRA requirements which overlap or are duplicative of those required at N.J.A.C. 8:39–13.4(b), up to a maximum of six hours of inservice training per year.)

SUBCHAPTER 26. ADVISORY NURSE STAFFING

8:39–26.1 Advisory structural organization for nurse staffing

Facilities with more than 200 licensed beds employ at least one full-time equivalent staff educator; facilities with between 100 and 200 licensed beds employ at least a half-time staff educator; or facilities with fewer than 100 licensed beds employ a staff educator at least one-fifth time.

8:39-26.2 Advisory policies and procedures for nurse staffing

(a) The facility establishes and implements a system for assigning nursing personnel on the basis of a classification system involving resident acuity.

(b) The facility uses a primary system in which nurse aides are assigned on a regular basis to specific residents to provide continuity of care.

8:39-26.3 Advisory nurse staffing amounts and availability

(a) A registered professional nurse is on duty at all times in facilities with fewer than 100 licensed beds, two registered professional nurses are on duty at all times in facilities with 100 to 200 licensed beds, and three registered nurses are on duty at all times in facilities with more than 300 beds.

(b) The facility provides direct nursing services pursuant to N.J.A.C. 8:39-25.2(b) of this chapter which are increased by at least ten percent.

(c) At least 50 minutes per resident per day of resident care is provided by licensed nurses, that is, registered professional nurses and licensed practical nurses. (This is an average. It is equal to one full-time equivalent nurse for every ten residents.)

(d) All nurse aides working in the facility have completed a training and orientation program to all services of at least two weeks full-time duration within the facility prior to their permanent assignment in the facility.

(e) Each resident care unit in the facility meets the nurse staffing requirements mandated in N.J.A.C. 8:39-25.2(b).

Case Notes

State's Medicaid reimbursement plan was not shown to be inadequate to provide recipients with nursing care required by federal law. New Jersey Ass'n of Health Care Facilities, Inc. v. Gibbs, D.N.J.1993, 838 F.Supp. 881.

State substantially complied with procedural requirements for computing Medicaid reimbursement rates for nursing facilities. New Jersey Ass'n of Health Care Facilities, Inc. v. Gibbs, D.N.J.1993, 838 F.Supp. 881.

8:39-26.4 Advisory qualifications for nurse staffing

(a) The director of nursing has a baccalaureate or master's degree in nursing or a health related field.

(b) A nurse practitioner or gerontologist nurse practitioner is available on staff or under contract with the facility to perform assessments and to provide consultation to other staff members.

(c) The facility employs a certified nurse practitioner or a clinical nurse specialist certified in gerontology or psychiatric nursing on at least a half time basis.

(d) A nurse who holds certification in gerontological nursing, rehabilitation nursing, or a related field of nursing from the American Nurses Credentialing Center of the American Nurses Association, is available on staff or under contract with the facility.

(e) The nurse educator who provides inservice training to nursing staff has completed the HIV/AIDS Train the Trainer program offered by the New Jersey Department of Health, Division on AIDS and the New Jersey State Nurses Association (320 West State Street, Trenton, N.J. 08618).

SUBCHAPTER 27. MANDATORY QUALITY OF CARE

8:39-27.1 Mandatory policies and procedures and practices for quality of care

(a) The facility shall provide and ensure that each resident receives all care and services needed to enable the resident to attain and maintain the highest practicable level of physical, emotional and social well-being, in accordance with individual assessments and care plans.

(b) All resident care policies shall be written and developed by a resident care committee, shall be available to physicians, staff, residents, their relatives or guardians, and the public, and shall be implemented in accordance with acceptable professional standards of practice.

(c) Residents under 18 years of age shall only be admitted to the facility if the admission has been approved by the New Jersey State Department of Health, in accordance with N.J.A.C. 8:39-43.

(d) Residents shall be weighed accurately every month. Whenever there is a gain or loss of five percent or more, a note shall be entered into the medical record stating whether the care plan should be modified. If the resident cannot be weighed, alternate measures shall be used to monitor weight change.

(e) Nonambulatory residents shall be repositioned at least once every two hours.

(f) The facility shall take preventive measures against the development of pressure sores, including assessing the resident's skin daily and minimizing friction and pressure against clothing and bed linens. When present, pressure sores shall be identified, documented, and treated.

(g) The facility shall conduct a bladder and bowel retraining program for selected residents on a 24-hour basis with results documented.

(h) Precautions shall be taken to prevent complications resulting from the use of nasogastric or gastrostomy tube feedings.

8:39–27.2 Mandatory policies and procedure for the use of restraints

(a) The standards in this section shall apply to the use of restraints in all resident care areas. Restraints are defined as devices, materials, or equipment that are attached or adjacent to a person and that prevent free bodily movement to a position of choice, with the exception of devices used for positioning supports.

(b) The facility shall have an interdisciplinary committee, or an equivalent process, which has responsibility for the use of restraints in the facility.

(c) The interdisciplinary committee or equivalent shall develop, review at least annually, revise as needed, and ensure implementation of written policies and procedures for the use of restraints. Guidance for such policies and procedures is provided in Appendix E.

(d) Psychopharmacological agents shall be administered only upon written physician's orders as part of the resident's treatment plan and shall not be used as a method of restraint, discipline, or for the convenience of staff.

(e) Policies and procedures for the application of restraints in an emergency shall be developed and implemented. Guidance for such policies and procedures is provided in Appendix E.

(f) In non-emergency cases, a resident shall be restrained only after the attending physician or another designated physician has executed an order for restraint as part of the resident's plan of care.

(g) The facility shall continuously attempt to remediate the resident's condition to eliminate or lessen the need for restraints through ongoing nursing or interdisciplinary assessment and intervention as required.

(h) The facility shall establish and implement written policies and procedures to ensure that appropriate nursing interventions while a resident is restrained are performed by nursing personnel. Guidance for such policies and procedures is provided in Appendix E.

(i) The facility shall establish and implement written policies and procedures for interventions by nursing personnel for residents in restraints for overnight sleeping. Guidance for such policies and procedures is provided in Appendix E.

8:39–27.3 Mandatory post-mortem policies and procedures

(a) Deceased residents shall be removed in a timely fashion from rooms where other residents are staying.

(b) Deceased residents shall receive post-mortem care, including cleaning and shrouding in conformance with each resident's religious practices. Prostheses shall accompany the body out of the facility.

(c) The next of kin or guardian shall be notified at the time of a resident's death. The deceased shall not be removed from the facility until pronounced dead with the death documented in the resident's medical record.

(d) The body of a deceased resident who, at the time of death, had a communicable disease, as defined in N.J.A.C. 8:57–1.2, shall be tagged accordingly before being released from the facility.

(e) Transportation of the deceased within and from the facility shall be conducted in a dignified manner.

(f) Personal effects and financial accounts of deceased residents shall be safeguarded.

8:39–27.4 Mandatory staffing amounts and availability for resident care

For each meal, the facility shall assign staff on the basis of resident needs to help residents who require assistance with eating.

8:39–27.5 Mandatory resident services for personal care

(a) Effective and safe measures shall be taken to ensure that residents do not harbor parasitic insects.

(b) Effective and safe measures shall be taken to ensure that residents are not malodorous.

(c) Any dehydrated resident shall be accurately evaluated and effectively treated.

(d) Oral hygiene care of the resident shall be performed by staff or the resident on a daily basis.

(e) The resident's hair and nails shall be groomed.

(f) Each resident shall be kept clean and dry.

(g) Each resident shall receive at least one bath (tub or shower) per week unless contraindicated.

(h) Each resident's bed shall be made daily. Clean linen shall be provided for each resident at least once a week or whenever linens are soiled or wet.

(i) Each resident shall have access to fresh drinking water or juice at all times, unless contraindicated.

(j) Non-bedfast residents shall be provided with the means for leaving and returning to their beds and rooms each morning and afternoon.

(k) Residents shall be assisted in performing either passive or active range-of-motion exercises every day, unless their level of physical activity makes this unnecessary.

(*l*) Toileting needs of all residents shall be met.

(m) Measures to prevent contractures shall be used, and contractures shall be identified, documented, and managed by rehabilitative nursing and physical therapy.

(n) Indwelling catheters shall not be used for the convenience of staff.

8:39–27.6 Mandatory general resident services

(a) Residents shall be afforded the opportunity to eat in a group setting unless contraindicated with the reasons noted in the resident's medical record. The need for feeding assistance shall not constitute an acceptable contraindication.

(b) Residents shall be afforded an opportunity to go outdoors on a regular basis.

(c) Clothing, including undergarments and footwear, shall be clean, comfortable, and personally assigned to each resident, and shall reflect personal preference and safety.

(d) Residents shall be encouraged and helped to select the clothing they will wear each day.

8:39–27.7 Mandatory supplies and equipment for resident care

(a) Prostheses, including eyeglasses, dentures, and hearing aids, shall be functional and individualized, and shall be kept available to the resident, unless the resident specifically rejects their use.

(b) Adaptive devices and equipment shall be functional and individualized, and shall be kept available to the resident unless the resident specifically rejects their use.

(c) All drinking water containers shall be washed daily and sanitized weekly. Containers that cannot be sanitized shall be discarded.

(d) The facility shall maintain at least one bag-valve-mask resuscitator.

(e) Bath thermometers or other temperature controls shall be used to monitor the temperatures of each bath or shower.

SUBCHAPTER 28. ADVISORY QUALITY OF CARE

8:39–28.1 Advisory policies and procedures for resident care

(a) The facility conducts scheduled interdisciplinary staff discussions, and discussions with residents and families, about the right of residents to die with dignity.

(b) The facility develops and provides individualized nonrestrictive equipment meeting individual needs which fosters and supports a restraint-free environment for all residents.

(c) The facility maintains an on-going and on-site program of preventative treatment and referral to mental health services which includes prevention, treatment, and referral directed by a qualified mental health professional.

8:39–28.2 Advisory resident care services

(a) There are education programs provided on at least a quarterly basis, open and accessible to residents, families, and significant others addressing the following issues:

1. The enhancement and maintenance of physical and mental well-being;
2. The prevention of deterioration;
3. The teaching of self-care; and
4. Death, dying and bereavement.

(b) There are education and training programs provided on at least a quarterly basis, open and accessible to families and significant others, which teach skills and help in the provision of support services that enable residents to leave the facility for visits and vacations.

(c) The facility promotes residents' sense of personal control in acquiring clothing, for example, through the establishment of a clothing concession in the facility or clothing vendors' periodic visits to the facility, the arrangement of shopping excursions, and/or the use of catalogue shopping by residents.

(d) Donated clothing is made available so that residents can select desired items.

(e) The facility provides a non-commercial washer and dryer for residents who wish to launder their own personal items.

SUBCHAPTER 29. MANDATORY PHARMACY

8:39–29.1 Mandatory pharmacy organization

(a) A New Jersey licensed pharmacist shall serve as director of pharmaceutical services or as consultant pharmacist.

(b) The facility shall have an interdisciplinary pharmacy and therapeutics committee, appointed by and reporting to the administrator and consisting of at least the administrator, a representative of the nursing staff, and the consultant pharmacist, with oversight as needed by the medical director. The committee may include a licensed pharmacist representing the provider pharmacy. The committee shall hold meetings as needed and records, including the dates of meetings, attendance, activities, findings, and recommendations, shall be maintained.

(c) The facility shall appoint a consultant pharmacist who is not also the director of pharmaceutical services or pharmacist provider and does not have an affiliation with either the director of pharmaceutical services or the pharmacist provider.

(d) If the facility keeps emergency injectable or oral controlled substances, a current Drug Enforcement Administration registration and Controlled Dangerous Substance registration for that location shall be available. (See N.J.S.A. 24:21–10 for registration requirements; registration application procedures are specified at N.J.A.C. 8:65–1.4.)

8:39–29.2 Mandatory drug administration policies and procedures

(a) The pharmacy and therapeutics committee shall establish and enforce procedures for documenting drug administrations in accordance with law.

(b) The facility shall have a system to accurately identify recipients before any drug is administered.

(c) Self-administration of drugs shall be permitted only as specified by the recommendations of the pharmacy and therapeutics committee or the interdisciplinary team. Self-administration procedures shall include, at a minimum, the following:

1. The written order of the prescriber;

2. Storage of medications in the resident's room, based on resident assessments;

3. Specifications for labeling, including directions for use;

4. Methods for documentation in the medical record, based on resident assessment;

5. Training of residents in self-administration by the nursing staff or the consultant pharmacist; and

6. Policies for individual assessment of residents' ability to self-administer medications.

(d) Medications shall be accurately administered by properly authorized individuals who shall ensure that the right drug is administered to the right resident in the right dose through the right route of administration at the right time.

8:39–29.3 Mandatory pharmacy reporting policies and procedures

(a) The consultant pharmacist shall conduct a drug regimen review and enter appropriate comments into the medical record of every resident receiving medication, at least monthly, on a pharmacist consultation sheet or another portion of the medical record in accordance with N.J.A.C. 13:39.

(b) The consultant pharmacist shall report any irregularities to the attending physician and to the director of nurses and these reports shall be acted upon.

(c) Drug product defects and adverse drug reactions shall be reported in accordance with the ASHP–USP–FDA (American Society of Hospital Pharmacists, United States Pharmacopoeia, Food and Drug Administration) Drug Product Defect Reporting System and the USP Adverse Drug Reaction Reporting System.

(d) Drug allergies shall be documented in the resident's medical record and on its outside front cover and communicated to the provider or dispensing pharmacy.

(e) Drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders. The resident's attending physician shall be notified of the automatic stop order prior to the last dose so that he or she may decide whether to continue use of the drug.

(f) If medication is withheld, the reason for withholding the medication shall be documented in the resident's medical record.

(g) Medication errors and adverse drug reactions shall be reported immediately to the director of nursing or the alternate to the director of nursing, and a description of the error or adverse drug reaction shall be entered into the medical record before the end of the employee shift. If the resident has erroneously received medication, the resident's physician shall be notified immediately. If a medication error originated in the pharmacy, the pharmacy shall be notified immediately.

8:39–29.4 Mandatory pharmacy control policies and procedures

(a) The label of each resident's individual medication container or package shall be permanently affixed and contain the following information:

1. The resident's full name;

2. The physician's name;

3. The prescription number;

4. The name and strength of drug;

5. The quantity dispensed;

6. The lot number;

7. The date of issue;

8. The expiration date;

9. The manufacturer's name if generic; and

10. Cautionary and/or accessory labels.

i. If a generic substitute is used, the drug shall be labeled according to the Drug Utilization Review Council Formulary, N.J.S.A. 24:6E–1 et seq. and N.J.A.C. 8:71.

ii. Required information appearing on individually packaged drugs or within an alternate medication delivery system need not be repeated on the label.

(b) If a unit dose distribution system is used ("unit dose drug distribution" means a system in which drugs are delivered to the resident areas in single unit packaging), the following requirements shall be met:

1. Each resident shall have his or her own medication tray labeled with the resident's name and location in the facility;

2. Each medication shall be individually wrapped and labeled with the generic or trade (brand) name and strength of the drug, lot number or reference code, expiration date, dose, and manufacturer's name, and shall be ready for administration to the resident;

3. Cautionary instructions shall appear on the resident's record of medication, and the system shall include provisions for noting additional information, including, but not limited to, special times or routes of administration and storage conditions; and

4. Delivery and exchange of resident medication trays shall occur promptly, and at least one exchange of resident medication trays shall occur every 24 hours, including weekends and holidays.

(c) Both over-the-counter and prescription medications may be kept as stock. A limited amount of prescription medications may be kept as stock for the administration of stat (emergency) doses, lost doses, or doses not sent by the provider pharmacy. These medications shall be approved by the pharmacy and therapeutics committee, monitored for accountability, and labeled to include drug name, drug strength, manufacturer's name, lot number, expiration date, recommended dosage for over-the-counter medications, and applicable cautionary and/or accessory labels.

(d) The consultant pharmacist shall:

1. Make monthly inspections of all areas in the facility where medications are dispensed, administered, or stored;

2. Periodically, as determined by the quality assurance program, observe a medication pass and review the crediting system; and

3. Document any problems and propose solutions to these problems.

(e) The contents of emergency kits shall have been approved by the pharmacy and therapeutics committee. Emergency kits shall be stored securely at each nursing unit, but not kept under lock and key, checked after each use, and checked at least monthly by the consultant pharmacist. Emergency kits shall not be accessible to residents but shall be accessible to staff in a timely manner.

(f) All medications repackaged by the pharmacy shall be labeled with an expiration date, name and strength of drug, lot number, date of issue, manufacturer's name if generic, and cautionary and/or accessory labels, in accordance with United States Pharmacopoeia (U.S.P.) requirements and applicable FDA regulations.

(g) The pharmacy and therapeutics committee shall establish and enforce procedures for removal of discontinued, unused, expired, recalled, deteriorated, and unlabeled drugs and intravenous solutions and for removal of containers of medications with worn, illegible, damaged, incomplete, or missing labels.

(h) All medications shall be stored in accordance with manufacturers' and United States Pharmacopoeia (U.S.P.) requirements and all medications shall be kept in locked storage areas.

(i) All medication destruction in the facility shall be witnessed by at least two persons, each of whom shall be either the pharmacist consultant, a registered professional nurse or a licensed practical nurse. A record of each instance of drug destruction shall be maintained.

(j) Where allowable by law, the facility shall generate a crediting mechanism for medications dispensed in a unit-of-use drug distribution system, or other system which allows for the re-use of medications. The crediting system shall be monitored by the provider pharmacist and a facility representative. (The operative date of these requirements shall be deferred until 12 months after the adoption of these rules.)

(k) The pharmacy and therapeutics committee shall establish and enforce procedures for the inventory of controlled substances in accordance with law.

(*l*) The facility shall implement written methods and procedures for obtaining prescribed prescription medications and biologicals from a pharmacy licensed by the New Jersey State Board of Pharmacy. The telephone number of the pharmacy and procedures for obtaining drugs shall be posted at each nursing unit.

(m) If the facility utilizes drugs marked "sample," the pharmacy and therapeutics committee shall develop a mech-

anism for the control and limitation of these drugs, in accordance with N.J.A.C. 13:35–6.6.

(n) The facility shall develop and implement a system whereby instructions for use are provided whenever medications are released to residents. Instructions shall be written in a manner intended to promote proper storage, secure handling, and safe administration of medications released to residents. Documentation of released medications shall be entered into the resident's medical record.

8:39–29.5 Mandatory pharmacy staff qualifications

If the facility maintains a pharmacy in-house, the pharmacy shall be licensed by the New Jersey State Board of Pharmacy, and shall possess a current Drug Enforcement Administration registration and a Controlled Dangerous Substance registration from the New Jersey State Department of Law and Public Safety.

8:39–29.6 Mandatory resident pharmacy services

(a) The facility shall provide pharmaceutical services, either directly or by contract with a provider pharmacy, 24 hours a day, seven days a week.

(b) If a resident obtains medications from a pharmacy which is not the facility provider pharmacy, the following conditions shall be met:

1. The pharmacy provider shall comply with all labeling requirements specified at N.J.A.C. 8:39–29.4(a); and

2. The facility shall establish a plan for obtaining the resident's drugs on an emergency basis.

(c) A resident may obtain medications from a pharmacy that is not the facility provider pharmacy unless:

1. The resident is expressly informed during the admission process and within the admission agreement that this service is not permitted in the facility, or

2. For existing residents, the facility submits documentation to the Department, prior to denying the request, demonstrating a significant risk to the health and safety of residents as a result of this practice.

8:39–29.7 Mandatory pharmacy supplies and equipment

(a) Medication containers and carts shall be handled properly to prevent damage, injury, and harm.

(b) Needles and syringes shall be stored, used, and disposed of in accordance with New Jersey State law, and a record shall be maintained of the purchase, storage, and disposal of needles and syringes.

(c) Controlled substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts and all other Federal and State laws and regulations concerning procurement, storage, dispensation, administration, and disposition. Controlled substances shall be stored separately from all other substances except in a unit dose drug distribution system.

(d) Pharmaceutical reference materials and other information sources about drugs, including investigational drugs, if used, shall be approved by the pharmacy and therapeutics committee and shall be current.

8:39–29.8 Mandatory pharmacy quality assurance

The pharmacy and therapeutics committee shall review medication errors and adverse drug reactions.

SUBCHAPTER 30. ADVISORY PHARMACY

8:39–30.1 Advisory pharmacy staff qualifications

The consultant pharmacist holds current certification by the Joint Board of Certification of Consultant Pharmacists.

8:39–30.2 Advisory pharmacy staffing amounts and availability

The consultant pharmacist or a licensed pharmacist representing the provider pharmacy provides or arranges for quarterly meetings open to residents, families, and interested others to discuss medication issues.

8:39–30.3 Advisory pharmacy resident services

The consultant pharmacist reviews the records of all newly admitted residents within 14 days of admission.

8:39–30.4 Advisory pharmacy quality assurance

The consultant pharmacist performs at least one Drug Utilization Evaluation (DUE) study per year, as part of a continuous quality improvement program.

SUBCHAPTER 31. MANDATORY PHYSICAL ENVIRONMENT

8:39–31.1 Mandatory space and environment; all facilities

(a) All exit doors to the facility shall be kept externally locked from 8:00 P.M. until 6:30 A.M.

(b) All residents shall have, in their rooms:

1. A bed and a mattress of the correct size to fit the bed;

2. A bed table with drawer;

3. A separate closet area and shelves for personal needs;

4. A privacy curtain around the bed excepting private rooms;

5. An unobstructed doorway;

6. Window coverings that are properly mounted and maintained;

7. Night lights; and

8. Call bells immediately accessible to the resident in bed or an individual at bedside.

(c) Glare from windows and reflections on floors and tables in the multi-purpose or dining room shall be controlled.

(d) All supplies and equipment in the facility shall be of such quality as not to break or tear easily.

(e) Each facility shall provide:

1. Good lighting at entrances and, where applicable, in parking areas;

2. Sounding devices or visual monitoring for all exit doors;

3. A comfortable chair for each resident in his or her room for use by the resident or resident's visitors;

4. An individual light for each resident in a room; and

5. A written policy for a procedure to refrigerate biologicals according to manufacturer's guidelines in case of emergency.

(f) Effective and safe controls shall be used to minimize and eliminate the presence of rodents, flies, roaches, and other vermin in the facility.

1. The premises shall be kept in such condition as to prevent the breeding, harborage, or feeding of vermin.

2. All openings to the outer air shall be effectively protected against the entrance of insects.

8:39–31.2 Mandatory housekeeping policies and procedures

(a) The facility shall provide and maintain a safe, clean, orderly and homelike environment for residents.

(b) The facility shall have a written schedule that determines the frequency of cleaning and maintaining all equipment, structures, areas, and systems.

(c) Mattresses, mattress pads and coverings, pillows, bedsprings, and other furnishings shall be properly maintained and kept clean and replaced as needed. They shall be thoroughly cleaned and disinfected on a regular schedule and whenever a new resident is using them.

(d) Scatter rugs shall be not permitted and floors shall be coated with slip-resistant floor finish.

(e) Carpeting shall be kept clean and odor free and shall not be frayed, worn, torn, or buckled.

(f) If pets are allowed in the facility, the facility shall provide safeguards to prevent interference in the lives of residents, and the facility should comply with guidelines for pets in health care facilities issued by the Veterinary Public Health Program of the New Jersey State Department of Health (See Appendix A).

(g) All equipment and environmental surfaces shall be clean to sight and touch.

8:39–31.3 Mandatory supplies and equipment

(a) All residents shall have, in their rooms:

1. Sheets, blankets, a pillow, and additional pillow if required or desired;

2. Supplies for oral needs, including a denture cup, if needed, and a clean toothbrush; and

3. A basin, comb, soap dish, and bedpan and/or urinal unless clearly unnecessary, stored at bedside.

(b) All resident rooms shall have a waste receptacle.

(c) A walker or a tripod cane shall be available to each resident who requires mechanical assistance to walk.

(d) A wheelchair shall be available to each resident who is not fully ambulatory.

(e) All equipment in the facility shall be in working order and shall be in good repair.

(f) All supplies and equipment in the facility shall be:

1. Up-to-date;

2. Free of hazards;

3. In conformance with applicable Federal standards;

4. Properly stored and maintained in accordance with manufacturers' instructions; and

5. Readily available when needed.

(g) Buildings and grounds shall be maintained in a clean and safe condition.

(h) There shall be a list of all cleaning and disinfecting agents used in the facility. The facility's list of all cleaning and disinfecting agents used shall be maintained with an accompanying list of corresponding antidotes.

(i) All cleaning and disinfecting agents shall be correctly labeled as to the product and its use, including agents that have been repackaged from a bulk source.

(j) Housekeeping and cleaning supplies shall be selected, measured, and used correctly and in accordance with manufacturers' instructions.

(k) When not in use, cleaning and disinfecting agents shall be stored separate from other supplies and shall be inaccessible to residents.

(*l*) All toilets and bathrooms shall be kept clean to sight and touch, in good repair, and free of odors that reflect poor housekeeping practices.

8:39–31.4 Mandatory staff qualifications for housekeeping

Facilities that contract with a housekeeping service shall use quality assurance measures to ensure that the housekeeping requirements of this chapter are met.

SUBCHAPTER 32. ADVISORY PHYSICAL ENVIRONMENT

8:39–32.1 Advisory smoking policies and procedures

There is a smoke-free policy in the facility, which is in accordance with N.J.A.C. 8:39–41.3(e)4.

8:39–32.2 Advisory physical environment for resident services

Areas and furnishings are color coded and/or accented for purposes of identification, function, ease of use, and/or safety.

8:39–32.3 Advisory space and environment for all facilities

(a) All resident rooms have aesthetically attractive wall hangings.

(b) The multi-purpose or dining room receives sunlight.

(c) The facility has attractive grounds, conducive to all residents' use, including shaded seating, gardens, and trees.

(d) Sound-absorbing materials are used throughout the facility (for example, rough texture, pile, acoustic tile, soft drapery).

(e) A multi-purpose room other than the dining room is available for group activities.

(f) A separate common room of at least 120 square feet is available on each unit for quiet passive activity such as visiting, reading and listening to music.

(g) The facility provides at least one single-bedded room in each nursing unit for isolation and/or special needs residents.

(h) There are plants and flowers (live or artificial) throughout the facility.

(i) A discrete and protected area of the facility is dedicated to free ambulation by confused and disoriented residents.

8:39–32.4 Advisory supplies and equipment

(a) All residents' rooms have handwashing facilities.

(b) All residents have in their rooms:

1. Attractive window treatments;
2. A bedspread; and
3. A lap robe.

(c) The facility establishes and implements a policy encouraging and assisting residents to utilize their own personal furnishings in their room.

SUBCHAPTER 33. MANDATORY QUALITY ASSESSMENT AND ASSURANCE

8:39–33.1 Mandatory quality assurance structural organization

(a) Quality assurance procedures shall be developed and implemented through a written plan which specifies time frames.

(b) Responsibility for the quality assurance program shall be assumed by designated individuals, who shall include the director of nursing services, a physician, and at least three other staff members, and who shall report directly to the administrator.

(c) Summary findings of the quality assurance program shall be submitted in writing to the administrator and the administrator shall take action which includes staff education or training on the basis of the program's findings.

(d) The quality assurance program shall review at least inventory control, maintenance inspections and reports, procedures for reporting incidents and hazards, and procedures for emergency response to incidents and hazards.

(e) Quality assurance findings shall be presented to the administrator with recommendations for corrective actions to address problems.

8:39–33.2 Mandatory quality assurance policies and procedures

(a) The quality assurance program shall identify problems in the care and services provided to the residents and shall include the audit of medical records.

(b) The quality assurance program shall monitor the performance of each service.

(c) The interdisciplinary committee or equivalent shall develop a program of quality assurance for the use of restraints that is integrated into the facility quality assurance program and includes regularly collecting and analyzing data to help identify problems and their extent, and recommending, implementing and monitoring corrective actions where needed.

(d) The quality assurance program for the use of restraints shall include the collection and evaluation of data at least quarterly. This data shall include at least the following:

1. All emergency restraint applications;

2. Indicators of the frequency of the use of restraints in the facility;

3. Evaluation of all cases in which there is:

i. A failure to obtain or receive a physician's order;

ii. A failure to follow and monitor procedures in accordance with N.J.A.C. 8:39–27.1(f) through (i); or

iii. A negative clinical outcome; and

4. Indicators of the frequency of the use of psychopharmacological agents.

(e) The quality assurance program shall monitor trends in the following:

1. The prevalence of pressure sores and skin breakdowns;

2. Psychoactive drug use;

3. Transfers to hospitals;

4. Medication errors;

5. Catheterization rates and catheterization care;

6. Weight loss and fluid intake;

7. Infection rates in all residents;

8. Resident depression;

9. Restoration of function following specific types of events, such as hip fractures;

10. Use of restraints;

11. Resident falls resulting in injury; and

12. Other possible indicators of level of quality care not listed in this subchapter.

(f) The quality assurance program shall develop and implement a system to measure the effectiveness of the reassessment process with respect to: frequency, comprehensiveness, accuracy, implementation, and interdisciplinary approach.

8:39–33.3 Mandatory quality assurance resident services

The quality assurance program shall include the gathering of resident care information from residents and visitors.

8:39–33.4 Mandatory quality assurance staff education and training

The quality assurance program shall evaluate staff education programs.

SUBCHAPTER 34. ADVISORY QUALITY ASSESSMENT AND ASSURANCE

8:39–34.1 Advisory quality assessment and assurance policies and procedures

(a) The facility develops and maintains an active, continuous quality improvement process which involves staff, residents, families and/or the community in improving the quality of services provided by the facility.

(b) The quality assurance program uses a resident classification system, such as acuities or specified diagnostic classifications, as an indicator in measuring resident outcomes.

(c) The quality assurance program includes periodic surveys of families to ascertain their satisfaction, suggestions, knowledge of resident's health conditions and treatments, and/or knowledge of facility policies and staff members' roles.

(d) There is a system to receive input on resident safety issues.

SUBCHAPTER 35. MANDATORY MEDICAL RECORDS

8:39–35.1 Mandatory organization for medical records

At least 14 days before a facility plans to cease operations, it shall notify the New Jersey State Department of Health in writing of the location and method of retrieval of medical records.

8:39–35.2 Mandatory policies and procedures for medical records

(a) Each active medical record shall be kept at the nurses' station for the resident's unit.

(b) The facility shall maintain for staff use a current list of standard professional abbreviations commonly used in the facility's medical records.

(c) Medical records shall be organized with a uniform format across all records.

(d) A medical record shall be initiated for each resident upon admission. The current medical record shall be readily available and shall include at least the following information, when such information becomes available:

1. Legible identifying data, such as resident's name, date of birth, sex, address, and next of kin, and person to notify in an emergency;

2. The name, address, and telephone number of the resident's physician, an alternate physician, and dentist;

3. Complete transfer information from the sending facility, including results of diagnostic, laboratory, and other medical and surgical procedures, and a copy of the resident's advance directive, if available, or notice that the resident has informed the sending facility of the existence of an advance directive;

4. A history and results of a physical examination, including weight, performed by the physician on admission, in accordance with N.J.A.C. 8:39–11.2(c) and results of the most recent examination by the physician, or NP/CNS, or New Jersey licensed physician assistant;

5. An assessment and plan of care made by each discipline involved in the resident's care;

6. Clinical notes for the past three months incorporating written, signed and dated notations by each member of the health care team who provided services to the resident, including a description of signs and symptoms, treatments and/or drugs given, the resident's reaction, and any changes in physical or emotional condition entered into the record when the service was provided;

7. All physician's orders for the last three months;

8. Telephone orders, each of which shall be countersigned by a physician within seven days, except for orders for non- prescription drugs or treatments, which shall be signed at the physician's next visit to the resident;

9. Records of all medications and other treatments which have been provided during the last three months;

10. Consultation reports for the last six months;

11. Records of all laboratory, radiologic, and other diagnostic tests for the last six months;

12. Records of all admissions, discharges, and transfers to and from the facility that occurred in the last three months;

13. Signed consent and release forms;

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

15. A discharge plan for those residents identified by the facility as likely candidates for discharge into the community or a less intensive care setting; and

16. A discharge note written on the day of discharge for residents discharged to the community, a less intensive care setting, another nursing home or hospital, which includes at least the diagnosis, prognosis, and psychosocial and physical condition of the resident.

(e) The medical record shall be completed within 30 days of discharge.

(f) If part of a care plan is not implemented, the record shall explain why.

(g) All entries in the resident's medical record shall be written legibly in ink, dated, and signed by the recording person or, if a computerized medical records system is used, authenticated.

1. If an identifier such as a master sign-in sheet is used, initials may be used for signing documentation, in accordance with applicable professional standards of practice.

2. If computer-generated orders with an electronic signature are used, the facility shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of computer-generated signatures.

3. If a facsimile communications system (FAX) is used, entries into the medical record shall be in accordance with the following procedures:

i. The physician, or NP/CNS, or New Jersey licensed physician assistant shall sign the original order, history and/or examination at an off-site location;

ii. The original shall be FAXed to the long-term care facility for inclusion into the medical record;

iii. The physician shall submit the original for inclusion into the medical record within 72 hours; and

iv. The FAXed copy shall be replaced by the original. If the facsimile reports are produced by a plain-paper facsimile process which produces a permanent copy, the plain-paper report may be included as a part of the medical record, as an alternate to replacement of the copy by the original report.

(h) If a resident or the resident's legally authorized representative requests, orally or in writing, a copy of his or her medical record, a legible photocopy of the record shall be furnished at a fee based on actual costs, which shall not exceed prevailing community rates for photocopying. ("Legally authorized representative" means spouse, immediate next of kin, legal guardian, resident's attorney, or third party insuror where permitted by law.) A copy of the medical record from an individual admission shall be provided to the resident or the resident's legally authorized representative within two working days of request.

1. The facility shall establish a policy assuring access to copies of medical records for residents who do not have the ability to pay; and

2. The facility shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The resident or his or her authorized representative, however, has a right to receive a full or certified copy of the medical record.

(i) Access to the medical record shall be limited only to the extent necessary to protect the resident. A verbal explanation for any denial of access shall be given to the resident or legal guardian by the physician and there shall be documentation of this in the medical record. In the event that direct access to a copy by the resident is medically contraindicated (as documented by a physician in the resident's medical record), the medical record shall be made available to a legally authorized representative of the resident or the resident's physician.

(j) The resident shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.

(k) The record shall be protected against loss, destruction, or unauthorized use. Medical records shall be retained for a period of 10 years following the most recent discharge of the resident, or until the resident reaches the age of 23 years, whichever is the longer period of time, a summary sheet shall be retained for a period of 20 years, and X-ray films or reproductions thereof shall be retained for a period of five years, in accordance with N.J.S.A. 26:8–5.

SUBCHAPTER 36. ADVISORY MEDICAL RECORDS

8:39–36.1 Advisory policies and procedures for medical records

(a) The name by which the resident wishes to be called is entered on the cover or first page of the medical record.

(b) There is a comprehensive discharge summary with statistical and narrative information from each service completed for each resident.

(c) The full medical records for all discharged or deceased residents are completed within 15 days.

(d) Telephone orders are countersigned by a physician within 48 hours except for orders for non-prescription drugs or treatments, which are countersigned within seven days.

8:39–36.2 Advisory staff education and training for medical records

The facility requires that staff use only standard professional abbreviations in medical records and maintains a current list of such abbreviations.

8:39–36.3 Advisory staff qualifications for medical records

(a) The facility utilizes the services of a medical record practitioner or consultant who is:

1. Certified or eligible for certification as a registered record administrator (RRA) or an accredited record technician (ART) by the American Medical Record Association (American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611); or

2. A graduate of a program in medical record science accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the Council on Education of the American Medical Record Association (American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611).

SUBCHAPTER 37. MANDATORY REHABILITATION

8:39–37.1 Mandatory policies and procedures for rehabilitation

(a) Physician orders for speech therapy, physical therapy, occupational therapy, and audiology services shall include specific modalities and the frequency of treatment, and shall be entered into the resident's medical record.

(b) Physician orders for medically appropriate speech therapy, physical therapy, and audiology services shall be properly followed, and the results of these services shall be entered into the resident's medical record.

8:39–37.2 Mandatory rehabilitation staff qualifications

(a) Speech-language pathology and audiology services shall be provided by one or more speech-language patholo-

gists who hold a current New Jersey license issued by the Audiology and Speech–Language Pathology Advisory Committee, Division of Consumer Affairs of the New Jersey State Department of Law and Public Safety.

(b) Physical therapy shall be provided by or under the direction of one or more physical therapists licensed by the New Jersey State Board of Physical Therapy Examiners.

(c) Occupational therapy shall be provided by or under the direction of an occupational therapist who is certified or eligible for certification as an occupational therapist, registered (OTR) by the American Occupational Therapy Association (American Occupational Therapy Association, 6000 Executive Boulevard, Rockville, Maryland 20852).

8:39–37.3 Mandatory rehabilitation staffing amounts and availability

Speech-language pathology evaluation, physical therapy evaluation, occupational therapy evaluation, and audiology evaluation shall take place within 72 hours of the original physician order, excluding weekends.

8:39–37.4 Mandatory rehabilitation supplies and equipment

(a) Space for rehabilitation therapy shall be provided in the facility. If space is unavailable, arrangements shall be made for transportation or transfer of residents who require rehabilitation therapy services.

(b) Visual privacy and provisions for auditory privacy shall be provided for residents during evaluation and rehabilitation treatment, when clinically indicated.

(c) If the facility provides physical therapy on-site, physical therapy equipment available to the residents shall include at least parallel bars, stairs, mats, and padded tables.

SUBCHAPTER 38. ADVISORY REHABILITATION

8:39–38.1 Advisory rehabilitation staff qualifications

Speech-language pathology and audiology services are provided by individuals who hold a Certificate of Clinical Competence issued by the American Speech–Language–Hearing Association.

8:39–38.2 Advisory rehabilitation space and environment

The facility has an examination and treatment room for rehabilitation therapy.

8:39–38.3 Advisory rehabilitation supplies and equipment

(a) In addition to parallel bars and stairs, physical therapy equipment available to residents includes a whirlpool for hydrotherapy and ultrasound.

(b) The occupational therapy program provides individually designed adaptive equipment as needed to enhance residents' independence.

SUBCHAPTER 39. MANDATORY SOCIAL WORK

8:39–39.1 Mandatory social work policies and procedures

A social worker shall develop and implement specific criteria to identify residents who are likely candidates for discharge into the community or a less intensive care setting and to coordinate discharge planning.

8:39–39.2 Mandatory social work staff qualifications

Social work services shall be provided by one or more social workers who are certified or licensed by the New Jersey State Board of Social Work Examiners, in accordance with the Social Worker's Licensing Act of 1991 (N.J.S.A. 45:15BB–1 et seq.) and all amendments thereto and with the rules of the New Jersey Board of Social Work Examiners, N.J.A.C. 13:44G.

8:39–39.3 Mandatory social work amounts and availability

(a) The facility shall provide an average of at least 20 minutes of social work services per week for each resident. (This is an average. It is equal to one full-time equivalent social worker for every 120 residents.)

(b) A social worker shall assist staff in coping with the personal needs and demands of particular residents.

8:39–39.4 Mandatory resident social work services

(a) A social worker shall interview the resident and family within 14 days before or after admission to the facility to identify any social work needs or problems, and to take a social history that includes family, education, and occupational background, adjustment and level of functioning, interests, support systems, and observations.

(b) A social worker shall provide counseling for residents and families.

(c) A social worker shall facilitate communication between staff and non-English speaking residents.

(d) A social worker shall offer information and help to each resident and family on obtaining financial assistance and on the meaning of administrative forms and releases to be signed by the resident or family.

(e) A social worker shall coordinate the facility's outreach services to the families of residents.

(f) A social worker shall coordinate discharge services for residents.

(g) A social worker shall perform advocacy services on behalf of the residents to ensure that concrete needs are met, such as clothing, laundry, and the resident's personal needs allowance if one is maintained.

(h) A social worker shall help residents and families identify and gain access to community services, using resource materials and a knowledge of the residents' needs and abilities.

(i) The facility shall provide clinical social work services to residents as needed and to families if related to issues that directly affect the resident.

8:39–39.5 Mandatory space and environment for social work

The facility shall provide visual and auditory privacy for resident or family social service interviews, and for confidential telephone calls by social workers.

SUBCHAPTER 40. ADVISORY SOCIAL WORK

8:39–40.1 Advisory staff qualifications for social work

A social worker has a master's degree in social work from an accredited university or education program. He or she should provide consultant services at least eight hours per month, or be on the facility's staff.

8:39–40.2 Advisory staff amounts and availability for social work

(a) A social worker is available to the facility on evenings and weekends at scheduled times or by previously arranged appointments for interaction with residents and families, and is available seven days a week in cases of emergency or serious need.

(b) A social worker assists staff with problems and issues related to aging and illness.

(c) A social worker orients nurse aides to the social needs of new residents before the resident's arrival in the facility.

8:39–40.3 Advisory resident social work services

(a) A social worker meets with the resident on the day of admission.

(b) A social worker conducts support groups for families.

(c) A social worker conducts group counseling sessions for residents and families.

(d) A social worker participates in pre-admission planning with residents and families prior to their admission to the nursing home.

(e) The social worker encourages and monitors a regular visiting pattern by families and provides outreach services to families where the visiting pattern has changed.

8:39–40.4 Advisory space and environment for social work

Social workers are to be provided with a private office equipped with a telephone or, in facilities with 60 or fewer licensed beds, with access to a private office equipped with a telephone.

8:39–40.5 Advisory social work staff education and training

The facility encourages the social worker to participate in community agency associations and other professional organizations.

SUBCHAPTER 41. MANDATORY PHYSICAL PLANT

8:39–41.1 Mandatory construction standards

(a) New construction, alterations and additions of Long Term Care Facilities shall comply with the Uniform Construction Code (N.J.A.C. 5:23) as adopted by the New Jersey Department of Community Affairs.

(b) Fire safety maintenance and retrofit of Long Term Care Facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs.

(c) Required annual maintenance inspections by the Department of Health shall be conducted in accordance with the 1994, as amended and supplemented, edition of the National Fire Protection Associations Life Safety Code; however, this code shall not be enforced to exceed the requirements of the Uniform Construction Code referenced in (a) above. (Copies of the Life Safety Code may be obtained from the National Fire Protection Association, Battery March Park, Quincy, MA 02200).

(d) The New Jersey Uniform Construction Code may be obtained from the Construction Code Element of the Department of Community Affairs, CN 805, Trenton, New Jersey 08625–0805.

(e) The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, CN 809, Trenton, New Jersey 08625–0809.

(f) Facilities undertaking new construction, renovations representing more than 25 percent of facility value, or additions of beds shall maintain a minimum ratio of one single-bedded room per 30 beds.

8:39–41.2 Mandatory general maintenance

(a) Personnel engaged in general maintenance activities shall receive orientation upon employment and, at least once a year, education or training in principles of asepsis, cross-infection control, and safe practices.

(b) There shall be a system for reporting physical plant, safety, and maintenance problems to a designated staff member and documentation of the correction of such problems.

(c) A current, written preventive maintenance program shall be implemented. Records of inspections and repairs shall be maintained for at least one year.

(d) Written instructions for operating and maintaining equipment shall be systematically retained and followed.

(e) The facility shall be kept in good repair and maintained without harm or jeopardy to residents.

(f) There shall be a maintenance contract on elevators that includes routine maintenance inspections.

(g) All life-sustaining equipment shall be plugged into outlets connected to an emergency power supply.

(h) The standby emergency power generator shall be checked weekly, tested under load monthly, and serviced in accordance with generally accepted engineering practices.

(i) Temperature and humidity shall be in accordance with requirements specified in the 1992–1993 Guidelines for Construction and Equipment for Hospital and Medical Facilities issued by the U.S. Department of Health and Human Services, Health Resources Administration that apply, depending on the time the building was constructed.

(j) There shall be a comprehensive, current, written preventive maintenance program for the electrical system that is documented and followed.

8:39–41.3 Mandatory fire and emergency preparedness

(a) Employees shall be trained in procedures to be followed in an emergency operations plan and instructed in the use of fire fighting equipment and resident evacuation of the buildings as part of their initial orientation and at least annually thereafter.

(b) Fire drills shall be conducted a total of 12 times per year, with at least one drill on each shift and one drill on a weekend. At least one drill shall be conducted in conjunction with the local fire department. An actual alarm shall be considered a drill if it is documented.

(c) Fire regulations and procedures shall be posted in each unit and/or department. A written evacuation diagram that includes evacuation procedures and locations of fire exits, alarm boxes, and fire extinguishers shall be posted conspicuously on a wall in each resident care unit and/or department throughout the facility.

(d) There shall be a procedure for investigating and reporting fires. All fires shall be reported to the New Jersey State Department of Health immediately by phone and followed up in writing within 72 hours. In addition, a written report of the investigation by the fire department containing all pertinent information shall be forwarded to the Department of Health as soon as it becomes available.

(e) Smoking regulations shall be developed, implemented, and enforced in accordance with N.J.S.A. 26:3D–1 et seq. and 26:3D–7 et seq.

1. Residents shall not be permitted to smoke in their rooms and in other secluded areas. The facility may enforce a no-smoking rule for staff and visitors.

2. Restricted smoking areas shall be designated and rules governing such smoking promulgated and rigidly enforced. Nonflammable ashtrays in sufficient numbers shall be provided in permitted smoking areas. In any area where smoking is permitted, there shall be adequate outside ventilation.

3. A facility may continue to enforce a smoke-free policy in effect on the implementation date of these rules and shall set forth this policy in its admission agreement.

4. At the facility's option, it may institute a smoke-free policy after the implementation date of these rules. Any prospective smoke-free policy shall be set forth in the facility's admission agreement and shall only apply to residents entering the facility on or after the policy's effective date. The facility shall protect the rights of residents who smoke by providing a designated area with adequate outside ventilation for controlled smoking. If inside, the designated smoking room shall be adequately ventilated to prevent recirculation of smoke to other areas of the facility. If outside, the designated area shall provide reasonable protection from inclement weather.

(f) The facility shall have a written comprehensive emergency operations plan developed in coordination with the local office of emergency management. This plan shall:

1. Identify potential hazards that could necessitate an evacuation, including natural disasters, national disasters, industrial and nuclear accidents, and labor work stoppage;

2. Identify the facility and an alternative facility to which residents would be relocated, and include signed, current agreements with the facilities;

3. Identify the number, type and source of vehicles available to the facility for relocation and include signed current agreements with transportation providers. Specially configured vehicles shall be included;

4. Include a mechanism for identifying the number of residents, staff, and family members who would require relocation and procedures for evacuation of non-ambulatory residents from the facility;

5. List the supplies, equipment, records, and medications that would be transported as part of an evacuation, and identify by title the individuals who would be responsible;

6. Identify essential personnel who would be required to remain on duty during the period of relocation;

7. Identify by title the persons who will be responsible for the following:

i. Activating the emergency operations plan, issuing evacuation orders, and notification of State and municipal authorities;

ii. Alerting and notification of staff and residents;

iii. Facility shutdown and restart;

iv. In place sheltering of residents and continuity of medical care; and

v. Emergency services such as security and firefighting; and

8. Describe procedures for how each item in (f)7 above will be accomplished.

(g) There shall be a written plan for receiving residents who are being relocated from another facility due to a disaster. This plan shall include at least an estimate of the number and type of residents the facility would accommodate and how staffing would be handled at different occupancy levels.

(h) Copies of the emergency operations plan shall be sent to municipal and county emergency management officials for their review.

(i) The administrator shall serve as, or appoint, a disaster planner for the facility.

1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan; or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management.

2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents.

(j) Any staff member who is designated as the acting administrator shall be knowledgeable about and authorized to implement the facility's plans in the event of an emergency.

(k) All staff shall be oriented to the facility's current plans for receiving and evacuating residents in the event of a disaster, including their individual duties.

(*l*) The facility shall ensure that residents receive nursing care throughout the period of evacuation and return to the original facility.

(m) The facility shall ensure that evacuated residents who are not discharged are returned to the facility after the emergency is over.

(n) The facility shall maintain at least a three-day supply of food and have access to an alternative supply of water in case of an emergency.

(*o*) The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance.

(p) The facility shall establish a written heat emergency action plan which specifies procedures to be followed in the event that the indoor air temperature is 82 degrees Fahrenheit or higher for a continuous period of four hours or longer.

1. These procedures shall include the immediate notification of the Department of Health.

2. In implementing a heat emergency action plan, a facility shall not prevent a resident from having a room temperature in his or her resident room in excess of 82 degrees Fahrenheit if the resident and the resident's roommate, if applicable, so desire, and if the resident's physician approves.

3. A heat emergency plan need not be implemented if the resident care areas are not affected by an indoor temperature in excess of 82 degrees Fahrenheit.

4. The heat emergency action plan shall include a comprehensive series of measures to be taken to protect residents from the effects of excessively high temperatures.

(q) The facility shall provide for and operate adequate ventilation in all areas used by residents. All areas of the facility used by residents shall be equipped with air conditioning and the air conditioning shall be operated so that the temperature in these areas does not exceed 82 degrees Fahrenheit.

8:39–41.4 Mandatory safety requirements

(a) An outlet that is connected to an emergency power supply shall be available wherever life-sustaining equipment is in operation.

(b) All draperies, curtains, and waste baskets shall be maintained flame retardant.

(c) All decorations shall be flame retardant. Open flames used for decoration or religious ceremonies shall not be left unsupervised.

(d) Cooking equipment shall be properly installed and maintained.

(e) Kerosene heaters and staff and resident-owned heating devices shall not be permitted.

(f) Extension cords shall not be permitted unless they are provided by the maintenance or engineering department of the facility, inspected regularly, and inventoried by the maintenance and engineering department. Extension cords shall be for temporary use only in resident care areas.

SUBCHAPTER 42. ADVISORY PHYSICAL PLANT

8:39–42.1 Advisory general maintenance

(a) Inspections or rounds are conducted at least monthly by a designated person or committee on all units and areas for maintenance problems. Results of these rounds are reported to the administrator.

(b) Maintenance services are under the supervision of an employee with at least one of the following:

1. Five years of experience in maintaining a physical plant;

2. A baccalaureate degree in engineering from an accredited college or university and two years of experience in maintaining a physical plant; or

3. Professional licensure in New Jersey as an engineer with one year of experience in maintaining a physical plant.

8:39–42.2 Advisory fire and emergency preparedness

(a) The facility conducts at least two evacuation drills each year, either simulated or using selected residents, at least one of which is conducted on a weekend or during an evening or night work shift. Results of the drills are to be summarized in a written report, which is shared with the county and municipal emergency management coordinators.

(b) A municipal, county, or State emergency management official conducts an education or training program in the facility on disaster planning and emergency preparedness at least once a year.

(c) Fire drills are conducted annually on each weekend shift.

8:39–42.3 Advisory safety

(a) There is a committee responsible for physical plant and resident safety and maintenance, which includes, at a minimum, representatives from administration, nursing, and maintenance services and meets at least quarterly.

(b) Regularly scheduled training meetings are held for residents and families, addressing safety issues in the facility.

SUBCHAPTER 43. NURSE AIDE IN LONG–TERM CARE FACILITIES TRAINING AND COMPETENCY EVALUATION PROGRAM

8:39–43.1 Fees

(a) Fees shall be charged by the testing agency to the long-term care facility training program, for each person for whom training and evaluation is sought, in the amount specified by the testing agency for the following, in accordance with N.J.S.A. 26:2H–12, except as noted in (b) below:

1. Clinical skills and written examination;
2. Clinical skills and oral examination;
3. Clinical skills examination only;
4. Written examination only;
5. Oral examination;
6. Duplicate or equivalency certificate, which shall be charged to the individual; and
7. Recertification certificate, which shall be charged to the individual if the individual is neither currently employed nor has been offered employment by a long-term care facility.

(b) The fee charged by the Department for approval of a training program shall be $75.00.

(c) The Department shall provide timely notice of any changes in fees specified in (a) above in the Public Notices section of the New Jersey Register.

(d) No nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may be charged for any portion of the program, identified in (a) above, including any fees for textbooks or other required course materials. The nurse aide may be charged only for the duplicate or equivalency certificates in (a)6 above if requested by the nurse aide as an individual.

(e) If a nurse aide who is not employed, or does not have an offer to be employed, as a nurse aide becomes employed by, or receives an offer of employment from, a licensed long-term care facility not later than 12 months after completing a nurse aide training and competency evaluation program, the facility shall provide for the reimbursement of reasonable costs incurred in completing the program on a pro rata basis during the period in which the individual is employed as a nurse aide. Such costs include, but are not limited to, fees for textbooks or other required course materials.

(f) No nurse aide shall be required, as a condition of employment, to pay the cost of the training program in the event of voluntary or involuntary termination of employment.

(g) All fees referenced at (a) and (b) above are nonrefundable.

Amended by R.1995 d.506, effective September 5, 1995.
See: 27 N.J.R. 2155(a), 27 N.J.R. 3485(a).

8:39–43.2 Nurse aide employment

(a) An individual who meets the following criteria shall be considered by the Department to be competent to work as a nurse aide in a licensed long-term care facility in New Jersey:

1. Has a currently valid nurse aide in long-term care facilities certificate and is registered in good standing on the New Jersey Nurse Aide Registry; or

2. Has been employed for less than four months and is currently enrolled in a State-approved nurse aide in long-term care facilities training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within four months of employment.

8:39–43.3 Nurse aide functions

The nurse aide shall function under the supervision and direction of a licensed nurse and perform tasks which are delegated in accordance with the provisions of N.J.A.C. 13:37–6.2, Delegation of selected nursing tasks.

8:39–43.4 Approval of nurse aide in long-term care facilities training program

(a) An approved training course for nurse aides shall consist of 90 hours of training. This shall include 50 hours of classroom instruction and 40 hours of clinical experience in a New Jersey licensed long-term care facility.

(b) The New Jersey competency evaluation shall consist of both a skills examination and a written/oral examination.

(c) For each nurse aide, an approved training course and the skills competency evaluation shall be scheduled so as to be completed within four months of the starting date of employment.

(d) A training course approved by the Department shall be conducted by an educational institution approved by the Department and the New Jersey State Department of Education subsequent to a review of each curriculum, or shall be conducted by a licensed long-term care facility. All training courses shall use the approved curriculum in order to be approved by the Department of Health. Educational institutions shall develop a written statement of the program's purpose, philosophy, and objectives and shall develop admission, tuition, and course completion policies which shall be available to students in written form.

(e) No resident care unit shall serve as the site of clinical instruction for more than one training course at a time.

(f) The training course for nurse aides shall not be used as a substitute for staff orientation or staff education programs.

(g) Classroom and clinical instruction for particular tasks or procedures shall be scheduled concurrently to the extent practicable.

(h) For training course approval, the following documents shall be submitted to the Certification Program of the Department with a check for the fee specified at N.J.A.C. 8:39–43.1, made payable to the New Jersey State Department of Health, 90 days prior to the proposed starting date of the training course:

1. Application for approval on the form provided by the Department;

2. Resume(s) of the nursing instructor(s)/evaluator(s) if they have not previously been approved by the Department;

3. A schedule for the training course, including specific dates, locations and times of classroom and clinical sessions; and

4. Documentation of availability of classroom and clinical facilities adequate to meet program needs, as indicated in each curriculum submitted.

(i) Written approval of the Department is required prior to enrollment of students and the commencement of the training program. Such approval shall be granted for a 24–month period.

(j) The Department may request submission of additional information or require the redesign and/or revision of the program materials. Redesign or revision of the program application does not ensure that approval will be granted.

(k) Any changes in a training course, such as changes in location, dates, times or instructor(s), shall be reported to the Certification Program of the Department by the licensed

nursing home administrator or administrator of the educational institution at least 30 working days prior to the planned change. No change may be implemented without the written approval of the Department.

(*l*) The Department may conduct unannounced site visits of a proposed program or an ongoing program.

(m) The Department may deny, suspend, or withdraw approval if it determines that a nurse aide training and/or skills competency evaluation program fails to meet the rules in this subchapter.

(n) The Department may deny, suspend, or revoke approval of a nurse aide training and/or skills competency evaluation program if the licensed long-term care facility has been the subject of an enforcement action in accordance with N.J.S.A. 26:2H–14 et seq. resulting in curtailment of admissions or in assessment of a civil money penalty of not less than $5,000.

(*o*) If the Department proposes to deny, suspend, or revoke approval of a nurse aide training and/or skills competency evaluation program, except where mandated by Federal requirements noted at (p) below, the facility or educational institution may, within 30 days, request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq. and 52:14F–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. Revocation of program approval shall not affect currently enrolled students, who shall be permitted to complete the program and clinical skills examination unless the Department determines that continuation of the program would jeopardize the health or safety of residents.

(p) Approval of a nurse aide training and/or skills competency evaluation program offered by or in a Medicare or Medicaid participating facility may be denied in accordance with 42 CFR 483.151(b).

(q) If a facility or educational institution plans to voluntarily terminate a nurse aide training and/or skills competency evaluation program, the facility or educational institution shall:

1. Provide the Department with a written statement of the rationale and plan for the intended closing;

2. Continue the program until the class schedule established for currently enrolled students has been completed; and

3. Notify the Department in writing of the closing date of the program at least 90 days prior to that date.

(r) If a nurse aide training and/or skills competency evaluation program is terminated due to denial or withdrawal of approval by the Department, the facility or educational institution shall:

1. Terminate the program after assisting in the transfer of students to other approved nurse aide training and/or skills competency evaluation programs;

2. Submit to the Department a list of the students who have transferred to another approved program, including the dates on which the students were transferred; and

3. Notify the Department that the requirements for closing have been fulfilled and give notice of final closing.

8:39–43.5 The New Jersey Curriculum for Nurse Aide Personnel in Long–Term Care Facilities

(a) The New Jersey Curriculum for Nurse Aide Personnel in Long–Term Care Facilities shall be the approved curriculum for a 90–hour training program. The entire content of the curriculum shall be taught. The course shall address nursing team member skills, basic skills, personal care skills, basic restorative skills, care of the cognitively impaired, mental health and psychosocial skills, resident rights, and communication skills and shall include the following modules:

1. MODULE I The Core Curriculum for the Nurse Aide in Long–Term Care Facilities Training and Competency Evaluation Program;

2. MODULE II Psychosocial Needs of the Resident;

3. MODULE III Physical Needs of the Resident;

4. MODULE IV Spiritual, Recreational and Activity Needs of the Resident.

(b) The Department shall issue a curriculum incorporating the specific elements of each module.

(c) A copy of the New Jersey Curriculum for Nurse Aide Personnel in Long–Term Care Facilities and the form needed to apply for approval of the training course may be obtained by contacting the following office:

Certification Program
New Jersey State Department of Health
CN 367
Trenton, NJ 08625–0367

8:39–43.6 Responsibilities of administrator

(a) The licensed nursing home administrator or administrator of the educational institution conducting the training program shall be responsible for implementation of the training program in accordance with the rules in this subchapter. This responsibility shall include, but not be limited to, ensuring the following:

1. The curriculum is implemented in accordance with the New Jersey Curriculum for Nurse Aide Personnel in Long–Term Care Facilities and with the rules in this subchapter;

2. Resident care provided by the student does not exceed the tasks and procedures which the student has satisfactorily demonstrated, as documented by the registered professional nurse on the Task and Procedure form. (The Task and Procedure form may be found in the New Jersey Curriculum for Nurse Aide Personnel in Long–Term Care Facilities); and

3. Job descriptions are established indicating the responsibilities of each nurse instructor/evaluator.

8:39–43.7 Nurse aide training program instructors

(a) Each nurse instructor/evaluator shall:

1. Be currently licensed in New Jersey as a registered professional nurse;

2. Possess at least three years of full-time or full-time equivalent experience in a health care facility;

3. Possess at least one year of full-time or full-time equivalent experience as a registered professional nurse in a licensed long-term care facility within the five years immediately preceding submission of the instructor/evaluator resume to the Certification Program of the Department for approval; and

4. Have successfully completed, if the individual is an evaluator, an evaluator's workshop course approved by the Department.

(b) The student to instructor ratio for classroom instruction shall not exceed a ratio of 20 students to one instructor.

(c) The student to instructor ratio for clinical instruction shall not exceed a ratio of 10 students to one instructor.

(d) Each student shall be under the supervision of the registered professional nurse instructor at all times when providing resident care as part of the student's clinical experience in the facility. The registered professional nurse instructor shall be responsible for evaluating the student's classroom and clinical performance.

(e) The resume of each nurse instructor/evaluator currently teaching the training course shall be available in the facility or educational institution.

(f) The nurse instructor shall be responsible for, but not limited to, the following:

1. Developing a lesson plan for each lesson in the curriculum;

2. Developing and implementing criteria, related to curricular objectives, for evaluating the classroom and clinical performance of students; and

3. Developing and implementing criteria to determine whether or not a student has satisfactorily completed a training course.

(g) The facility or educational institution conducting a training program shall maintain on file a copy of the lesson plans for the course. Each lesson plan shall state, at a minimum, the following:

1. The behavioral objective(s) of the lesson;

2. The content of the lesson;

3. A description of clinical activities for each lesson, consistent with the objectives in the curriculum;

4. The hours of instruction;

5. Method(s) of presentation and teacher strategies; and

6. Method(s) for evaluation of students with respect to their classroom and clinical performance in the facility.

8:39–43.8 Student records and attendance

(a) Each facility or educational institution which conducts a training program shall establish a student record for each student. The student record shall include, at a minimum, the following:

1. The beginning and ending dates of the training course;

2. An attendance record;

3. A signed Task and Procedure Form; and

4. The instructor's evaluation of the student's classroom performance and clinical performance in the facility.

(b) The facility shall retain the records specified at (a)1, 2 and 4 above for at least four years.

(c) The facility or educational institution conducting a training program shall ensure that a student who is absent receives a reasonable and timely opportunity to obtain the classroom and/or clinical instruction missed, as documented in the student's record.

(d) If a nurse aide training and/or skills competency evaluation program is terminated but the facility or educational institution continues to operate, the facility or educational institution shall assume responsibility for the records of students and graduates. The Department shall be advised, in writing of the arrangements made to safeguard the records.

(e) If a nurse aide training and/or skills competency evaluation program is terminated and the facility or educational institution ceases to operate, the records of students and graduates shall be transferred to an agency acceptable to the Department.

8:39–43.9 Training program evaluation

(a) The facility or educational institution conducting a training program shall develop, implement, and document a process for evaluating the effectiveness of the training pro-

gram. The evaluation process shall include, at a minimum, the following:

1. Assignment of responsibility for the evaluation process;

2. An annual written evaluation report, including findings, conclusions, and recommendations;

3. A written evaluation by the facility or educational institution of instructor(s)/evaluator(s) performance;

4. Written evaluations, by students, of the training program; and

5. Statistical data, which shall be maintained on file in the facility or educational institution. The statistical data shall include, at a minimum, the following for each course:

i. Beginning and ending dates;

ii. Number of students enrolled;

iii. Number and percentage of students who satisfactorily completed the course;

iv. Number and percentage of students who failed the course;

v. Number and percentage of students who passed the New Jersey Nurse Aide Competency Evaluation Program, including written/oral and skills; and

vi. Number and percentage of students who failed the New Jersey Nurse Aide Competency Evaluation Program, including written/oral and skills.

(b) The facility or training program shall retain all evaluation reports for at least three years and shall submit a report to the Department upon request.

8:39–43.10 Competency examination

(a) The Department shall establish the passing scores for the clinical skills and written/oral examinations. A candidate shall pass both the skills and the written/oral examinations prior to certification.

1. Upon satisfactory completion of the approved 90–hour training program, an applicant for nurse aide certification shall register for the next scheduled administration of the clinical skills competency examination. A person who fails to pass the skills competency examination may retake the examination. If the person fails the third attempt to pass the examination, he or she shall take another training course approved in accordance with N.J.A.C. 8:39–43.4 before proceeding to take the Department's skills competency examination again.

2. The clinical skills competency examination shall be administered to the applicant by a State-approved evaluator other than the applicant's training program instructor.

3. Upon passing the clinical skills competency examination, an applicant for nurse aide certification becomes eligible to take the written/oral examination. A person who fails to pass the written/oral examination may retake the examination. If the person fails the third attempt to pass the examination, he or she shall take another training course approved in accordance with N.J.A.C. 8:39–43.4 before proceeding to take the Department's written/oral examination again.

(b) The applicant shall pass the Department's nurse aide competency evaluation program in order to be listed on the New Jersey Nurse Aide Registry. The competency evaluation score reports shall be reported to the applicant as "pass/fail."

8:39–43.11 Application to take the competency examination and for certification as a nurse aide in long-term care facilities

(a) An applicant to take the competency examination and for certification as a nurse aide in long-term care facilities shall submit the following to the Department or its designated agent:

1. Evidence of satisfactory completion of a nurse aide in long-term care facilities training program approved by the Department, unless the need is waived in accordance with N.J.A.C. 8:39–43.12; and

2. Evidence in such form as the Department may prescribe that the applicant is of good moral character, including at least the following:

i. Attestation that the applicant does not engage in the illegal use of controlled substances; and

ii. Attestation that the applicant has never been convicted of, or pleaded guilty to, any crime or disorderly persons offense of the types set forth in Title 2C of the New Jersey Statutes. Evidence demonstrating rehabilitation from such convictions, if any, may be submitted to the Department.

8:39–43.12 Waiver of requirement to complete training program

(a) The following persons may take the Department's written/oral competency examination without first completing a nurse aide training course and clinical skills evaluation approved in accordance with N.J.A.C. 8:39–43:

1. Student or graduate nurses pending licensure who submit evidence of successful completion of a course in the fundamentals of nursing;

2. Persons who submit evidence of the successful completion of a course in the fundamentals of nursing within the 12 months immediately preceding application to take the written/oral competency examination;

3. Persons certified as a nurse aide in long-term care in another state by a state governmental agency and listed on that state's nurse aide registry, who do not meet the requirements for equivalency specified at N.J.A.C. 8:39–43.18; and

4. Persons who have had training and experience as a nurse aide in a military service, equivalent to that of a nurse aide.

8:39–43.13 Certificates

(a) Nurse aide certificates shall be valid for a period of two years from the date of issuance.

(b) Nurse aide in long-term care facilities certificates issued by the Department or its designated agent shall be forwarded to the individual certified nurse aides.

(c) A certificate shall not be retained by a long-term care facility as a condition of employment of a nurse aide.

(d) Nurse aide certificates are not transferable by sale, gift, duplication, or other means and shall not be forged or altered.

8:39–43.14 Revocation of a certificate

(a) A certificate issued to a nurse aide in accordance with these rules shall be revoked in the following cases:

1. Conviction for resident abuse or neglect or misappropriation of resident property;

2. Conviction or guilty plea as specified at N.J.A.C. 8:39–9.3(d)2; or

3. Sale, purchase, or alteration of a certificate; use of fraudulent means to secure the certificate, including filing false information on the application; or forgery, imposture, dishonesty, or cheating on an examination.

(b) If the Department proposes to suspend, revoke, or deny certification of a nurse aide in a long-term care facility, the aggrieved person may request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq. and 52:14F–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

8:39–43.15 Recertification

(a) The nurse aide shall file an application for recertification. The Department shall require the renewal and updating of a nurse aide listing on the registry at least once every two years on a schedule established by the Department.

(b) In order to be recertified, an individual shall have been employed performing nursing or nursing-related services for at least seven hours, either directly in a licensed health care facility or under supervision provided through a licensed health care facility, within the past 24 months from the date of expiration as specified on the nurse aide certificate and shall not have been convicted of, or pleaded guilty to, a criminal charge resulting from resident abuse and/or neglect, misappropriation or theft of a resident's property, or other crime or offense as specified at N.J.A.C. 8:39–43.11(a)2ii.

(c) The facility shall maintain records sufficient to verify the previous employment of nurse aides who are not currently working but who were employed by the facility in accordance with the time limitation specified at (b) above for recertification. The licensed nursing home administrator shall verify such employment by signing the individual's recertification application upon request.

8:39–43.16 Nurse aide registry

(a) The Department shall establish and maintain a nurse aide registry. The nurse aide registry shall include, but not be limited to, the following information for each individual who has successfully completed an approved nurse aide training program and competency evaluation program and is employed in a long-term care facility:

1. The individual's full name;

2. The individual's home address;

3. The listing number assigned to the individual by the state when he or she successfully completes the competency evaluation program;

4. The individual's date of birth;

5. The individual's most recent employer, the date of hire, and the date of termination, if applicable, by that employer;

6. The date the individual passed the competency evaluation program;

7. The date the listing expires;

8. The name and address of the approved nurse aide training program;

9. Any substantiated findings of resident abuse, neglect, or misappropriation of resident property, affirmed by a conviction in a court of law or a hearing in accordance with N.J.A.C. 8:39–43.17(d), in which the individual has been afforded notice and a right to a hearing. All such reports shall remain in the registry permanently; and

10. Any statement by the nurse aide disputing the allegations underlying the convictions or findings in (a)9 above, in a format prescribed by the Department.

(b) The information at (a)1, 6, 9 and 10 above shall be available to the public.

8:39–43.17 Hearings for resident abuse, resident neglect, or misappropriation of property

(a) Upon receipt of a finding that a nurse aide has abused, neglected, or misappropriated the property of a resident, resulting from an investigation by the Office of the Ombudsman for the Institutionalized Elderly, the Department, or other state or local governmental agency, including criminal justice authorities, the Department shall determine whether the finding is valid and is to be entered onto the nurse aide registry.

(b) Prior to entering the finding on the nurse aide registry, the Department shall provide a notice to the certified nurse aide identifying the intended action, the factual basis and source of the finding, and the individual's right to a hearing.

(c) The notice in (b) above shall be transmitted to the individual in such a way as to provide an opportunity of at least 30 days prior to the entry to request a hearing. If a hearing is requested, it shall be conducted by the Office of Administrative Law or by a Departmental hearing officer in accordance with hearing procedures established by the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq. and 52:14F–1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(d) No further right to an administrative hearing shall be offered to individuals who have been afforded a hearing before a state or local administrative agency or other neutral party, or in a court of law, at which time the aide received adequate notice and an opportunity to testify and to confront witnesses, and where there was an impartial hearing officer who issued a written decision verifying the findings of abuse, neglect, or misappropriation of property of a resident. The individual shall have a right to enter a statement to be included in the registry contesting such findings.

8:39–43.18 Equivalency for nurse aides registered in other states

(a) A nurse aide certificate received in another state or territory of the United States may be entered on the registry, provided that the following conditions are satisfied:

1. The Department receives documentation from the state's or U.S. territory's registry that such nurse aide has completed a training and competency evaluation program at least equal to that required in New Jersey; and

2. The nurse aide has not been convicted of any crimes and has no documented findings of abuse, neglect, or misappropriation of resident's property on the registry.

8:39–43.19 Expiration of certification

(a) If an individual fails to become recertified in accordance with N.J.A.C. 8:39–43.15, the name of the person shall be removed from the New Jersey nurse aide registry.

(b) In order for an individual to be reentered onto the New Jersey nurse aide registry, the individual shall successfully complete a training course approved in accordance with N.J.A.C. 8:39–43.4 and shall pass the New Jersey competency evaluation. If the individual became initially certified within the five years immediately preceding reapplication, and can demonstrate that he or she has been employed as a nurse aide in a long-term care facility for at least seven hours during the 24 consecutive months immediately preceding application for recertification, the individual shall be recertified upon passing the New Jersey competency evaluation, and completion of a training course shall not be required.

8:39–43.20 Employment of a nurse aide

(a) No licensed long-term care facility shall employ a person as a nurse aide without making inquiry to the New Jersey nurse aide registry and to any other state nurse aide registry in which the facility has a good faith belief the nurse aide is registered.

(b) Registry confirmation of a nurse aide certification shall not be sufficient to satisfy the requirement for reference checks identified at N.J.A.C. 8:39–9.3(d).

(c) The facility shall verify that the individual seeking employment as a nurse aide possesses a valid nurse aide in long-term care facilities certificate or shall ensure that the individual becomes certified within four months of employment.

SUBCHAPTER 44. RESPITE CARE SERVICES

8:39–44.1 Scope and purpose

(a) Long-term care facilities are authorized by law to accept short-term residents whose regular caregivers are participating in a respite care program. A caregiver is defined as any individual, paid or unpaid, who provides regular in-home care for an elderly, disabled, or cognitively impaired person.

(b) When a caregiver desires respite from this responsibility, continuity of care for the elderly, disabled, or cognitively impaired person is available through temporary placement in a long-term care facility for a period of time specified in advance.

(c) The standards in this subchapter apply only to those long-term care facilities that operate a respite care program.

8:39–44.2 Mandatory policies and procedures

(a) The long-term care facility shall have written respite care policies and procedures that are retained by the administrative staff and available to all staff and to members of the public, including those participating in the program.

(b) The facility shall obtain the following information from the resident's attending physician prior to admission:

1. A summary of the resident's medical history and most recent physical examination;

2. Signed and dated medication and treatment orders for the resident's stay in the facility; and

3. Phone numbers of the attending physician and an alternate physician for consultation or emergency services.

(c) The facility shall choose whether to follow the resident care plan provided by the attending physician or to establish a plan in accordance with N.J.A.C. 8:39–11. The facility is exempt from compliance with N.J.A.C. 8:39–11, if it chooses to follow the care plan provided by the resident's attending physician.

(d) The facility shall obtain the following information from the resident's regular caregiver(s):

1. Nursing care needs, including personal hygiene and restorative maintenance care;
2. Dietary routine and preferences; and
3. Social and activity routine and preferences.

(e) The facility shall choose whether to follow the dietary, social, and resident activity plan provided by the caregiver(s) or to establish a plan in accordance with N.J.A.C. 8:39–7, 17 and 39. The facility is exempt from compliance with N.J.A.C. 8:39–7, 17 and 39, if it chooses to follow the plan provided by the caregiver(s).

(f) The pharmacy and therapeutics committee shall establish policies and procedures for providing pharmacy services for the respite care program according to the New Jersey State Board of Pharmacy and other applicable rules and regulations. These policies and procedures shall include the following:

1. Options, if any, for provision of resident medications by sources other than the facility's usual provider(s);
2. Labeling and packaging of medications;
3. Self-administration of medications, if applicable; and
4. Control measures.

(g) The facility shall apply to respite care residents all the standards contained in N.J.A.C. 8:39, except those exemptions cited in this rule, and in the following: N.J.A.C. 8:39–4.1(a)31, 4.1(b), 5.1(a)–(e), 11.3(a), 15.1(b), subchapter 29, 35.2(d)3 to 16, and 37.3.

8:39–44.3 Advisory staffing

A long-term care facility should assign specific staff members to an individual respite care resident to provide continuity of care during the resident's stay in the facility.

SUBCHAPTER 45. ALZHEIMER'S/DEMENTIA PROGRAMS—MANDATORY STANDARDS

8:39–45.1 Scope and purpose

Long-term care facilities may establish Department approved programs to meet the needs of residents with Alzheimer's disease or other dementias. In addition to meeting all mandatory requirements specified in subchapters 1 through 43 of the long-term care licensing standards, N.J.A.C. 8:39 and the rules in this subchapter, the program shall provide individualized care based upon assessment of the cognitive and functional abilities of Alzheimer's and dementia residents who have been admitted to the program. The standards in this subchapter shall apply only to those long-term care facilities that operate a Department approved Alzheimer's/dementia program, as defined at N.J.A.C. 8:39–2.9(f).

SUBCHAPTER 46. ALZHEIMER'S/DEMENTIA PROGRAMS—ADVISORY STANDARDS

8:39–46.1 Advisory Alzheimer's/dementia program policies and procedures

(a) The long-term care facility has written policies and procedures for the Alzheimer's/dementia program that are retained by the administrative staff and available to all staff and to members of the public, including those participating in the program.

(b) The facility has established criteria for admission to the program and criteria for discharge from the program when the resident's needs can no longer be met, based upon an interdisciplinary assessment of the resident's cognitive and functional status.

8:39–46.2 Advisory staffing

(a) Staffing levels are sufficient to provide care and programming, based upon resident census in the program and an interdisciplinary assessment of the cognitive and functional status of residents in the program.

(b) The facility has established criteria for the determination of each staff member's abilities and qualifications to provide care to residents in the program.

(c) The facility provides an initial and ongoing educational, training and support program for each staff member which includes at least the causes and progression of dementias, the care and management of residents with dementias, and communication with dementia residents.

(d) Each Alzheimer's/dementia program has a full-time employee, with specialized training and/or experience in the care of residents with dementia, who has been designated as coordinator/director and whose duties include responsibility for the operation of the program.

(e) A consultant gerontologist is available to residents and to the program, as needed, to address the medical needs of the resident. "Consultant gerontologist" means a physician, psychiatrist, or geriatric nurse practitioner who

has specialized training and/or experience in the care of residents with dementia.

8:39–46.3 Advisory environmental modification

(a) The program includes appropriate facility modifications to ensure a safe environment which allows each Alzheimer's/dementia resident to function with maximum independence and success.

(b) The facility has developed safety policies and procedures and a security monitoring system which are specific to the program, based upon the physical location of the program as well as the individual needs of the Alzheimer's/dementia residents.

(c) The facility provides indoor and outdoor arrangements which allow residents freedom to ambulate in a controlled setting.

(d) Doors are marked with items familiar to the individual resident which enhance the resident's ability to recognize his or her room, and bathrooms are specially marked and easily accessible.

8:39–46.4 Advisory activity programming

(a) The Alzheimer's/dementia program provides a daily schedule of special activities, seven days a week and at least two evenings per week, designed to maintain residents' dignity and personal identity, enhance socialization and success, and to accommodate the various cognitive and functional abilities of each resident.

8:39–46.5 Advisory nutrition

(a) The Alzheimer's/dementia program provides nutritional intervention as needed, based upon assessment of the eating behaviors and abilities of each resident. Interventions may include, but are not limited to, the following:

1. Verbal and non-verbal eating cues;
2. Modified cups, spoons, or other assistive devices; and
3. Simplified choices of foods or utensils.

(b) The Alzheimer's/dementia program provides a small dining room, separate room, or designated dining area furnished to meet the needs of the residents, with staff members or trained volunteers to assist.

8:39–46.6 Advisory social services

(a) The facility provides individual and group counseling to residents if appropriate, utilizing techniques designed to reach the dementia resident and to maintain the resident's maximum level of functioning.

(b) Families are encouraged and provided with opportunities to participate in planning and providing resident care.

(c) The facility provides individual and group counseling, support and education groups for families, and information and referral on bioethical and legal issues related to dementia, including competence, guardianship, conservatorship and advance directives.

(d) Family members are referred to community Alzheimer's Disease Support Groups or other family counseling agencies, as required.

(e) Discharge care plans, including preparation for discharge from the unit, are discussed with the legal next of kin, and, if possible, with the resident at the time of admission to the program.

APPENDIX A

GUIDELINES AND CONSIDERATIONS FOR PET FACILITATED THERAPY IN NEW JERSEY INSTITUTIONS

I. All Pets

A. Companion pets should not pose a threat or nuisance to the patients, staff, or visitors because of size, odor, sound, disposition, or behavioral characteristics. Aggressive or unprovoked threatening behavior should mandate the pet's immediate removal.

B. Animals which may be approved include: dogs, cats, birds (except carnivorous), fish, hamsters, gerbils, guinea pigs, and domestic rabbits. Wild animals such as turtles and other reptiles, ferrets, and carnivorous birds should not be permitted in the program.

C. In order to participate, dogs or cats should be either altered or determined not to be in estrus ("heat").

D. Sanitary constraints:

1. Pets should be prohibited from the following areas:
   a. food preparation, storage, and serving areas, with the exception of participating resident's bedroom;
   b. areas used for the cleaning or storage of human food utensils and dishes;
   c. vehicles used for the transportation of prepared food;
   d. nursing stations, drug preparation areas, sterile and clean supply rooms;
   e. linen storage areas; and
   f. areas where soiled or contaminated materials are stored.
2. Food handlers should not be involved in the clean-up of animal waste.
3. The administrator is responsible for acceptable pet husbandry practices and may delegate specific duties to any other staff members except food handlers. The areas of responsibility include: feeding and watering, food cleanup/cage cleaning, exercising, and grooming.

4. Spilling or scattering of food and water should not lessen the standard of housekeeping or contribute to an increase in vermin or objectionable odor.
5. Dogs and cats must be effectively housebroken and provisions made for suitably disposing of their body wastes.
6. Animal waste should be disposed of in a manner which prevents the material from becoming a community health or nuisance problem and in accordance with applicable sanitation rules and ordinances. Accepted methods include disposal in sealed plastic bags (utilizing municipally approved trash removal systems) or via the sewage system for feces.
7. Proper and frequent handwashing shall be a consideration of all persons handling animals.

E. Animals found to be infested with external parasites (ticks, fleas, or lice) or which show signs of illness (for example, vomiting or diarrhea) should be immediately removed from the premises and taken to the facility's veterinarian.

F. The parent or guardian of a child bitten by a dog, cat, or other animal, when no physician attends such child, shall, within 12 hours after first having knowledge that the child was so bitten, report to the person designated by law or by the local board, under authority of law, to receive reports of reportable communicable diseases in the municipality in which the child so bitten may be the name, age, sex, color, and precise location of the child (*N.J.R.S.* 26:4–80).

If an adult is bitten by a dog, cat, or other animal and no physician attends him, the adult, or, if he is incapacitated, the person caring for him, shall report to the person designated by law or by the local board of health to receive reports of communicable diseases in the municipality in which the adult so bitten may be the name, age, sex, color, and the precise location of the adult. The report shall be made within 12 hours after the adult was so bitten, or if he is incapacitated, the report shall be made within 12 hours after the person caring for him shall first have knowledge that the adult was so bitten (*N.J.S.A.* 26:4–81).

G. The local health department must be promptly notified by telephone of any pet which dies on the premises.
1. If the deceased is a bird, the body should be immediately taken to the facility's veterinarian. If the veterinarian is not available, the deceased bird should be securely wrapped in impermeable wrapping material and frozen until veterinary consultation is available. Payment for a laboratory examination should be the responsibility of the institution, or the pet's owner.
2. If the deceased is another type of animal, the body should not be disposed until it is determined by the local department of health that rabies testing is not necessary.

H. The rights of residents who do not wish to participate in the pet program must be considered first. Patients not wishing to be exposed to animals should have available a pet free area within the participating facility.

II. Visiting Pets

A. Visiting pets are defined as any animal brought into the facility on a periodic basis for pet therapy purposes. The owner should accompany the animal and be responsible for its behavior and activities while it is visiting at the facility.

B. Visiting dogs should:
1. be restricted to the areas designated by the facility administrator;
2. maintain current vaccination against canine diseases of distemper, hepatitis, leptospirosis, parainfluenza, parvovirus, coronavirus, bordetella (kennel cough), and rabies. Proof of vaccination shall be included on a health certificate which is signed by a licensed veterinarian and kept on file at the facility;
3. be determined not to be in estrus ("heat") at the time of the visit;
4. be licensed and wear an identification tag on the collar, choker chain, or harness, stating the dog's name, the owner's name, address, and telephone number; and
5. be housebroken if more than four months of age. Younger dogs may be admitted subject to the approval of the administrator.

C. Visiting cats should:
1. Maintain current vaccination against feline pneumonitis, panleukopenia, rhinothracheitis, calcivirus, chlamydia, and rabies. Proof of vaccination should be included on a health certificate which is signed by a licensed veterinarian and kept on file at the facility.
2. Determined not be in estrus ("heat") at the time of the visit.

D. Visiting hamsters, gerbils, guinea pigs, domestic rabbits, laboratory mice, or rats:
1. The owner should be liable and responsible for the animal's activities and behavior.

E. No visiting birds should be allowed to participate in the program.

III. Residential Pets:

A. Residential pets are defined as any animal which resides at a facility in excess of four hours during any calendar day and is owned by a staff member, patient, the facility, or a facility approved party. The financial responsibility for the residential animal's maintenance is the animal owner's responsibility.

B. All documentation of compliance will be maintained by the facility administrator in a file for review and inspection. The official health records should include the rabies vaccination certificate and a current health certificate.

C. Residential animals should have a confinement area separate from the patients where they can be restricted when indicated. An area should be available for each participating unit and should be approved by the administrator.

D. A licensed veterinarian should be designated as the facility's veterinarian and should be responsible for establishing and maintaining a disease control program for residential pets.

E. Specific Species:

1. Residential dogs should:

a. Maintain current vaccination against canine diseases of distemper, hepatitis, leptospirosis, parainfluenza, parvovirus and rabies. In addition, the animal's file should include a currently valid Rabies Vaccination Certificate, NASPHV # 51. A three year type rabies vaccine should be utilized.

b. Have an annual heartworm test commencing at one year of age and should be maintained on heartworm preventive medication.

c. Have a fecal examination for internal parasites twice yearly. Test results should be negative before the dog's initial visit to the facility.

d. Follow the recommended procedures of the facility's veterinarian for controlling external parasites.

e. Be neutered.

f. Be licensed with the municipality and wear an identification tag on the collar, choker chain, or harness, stating the dog's name, the owner's name, address, and telephone number.

g. Have a health certificate completed by a licensed veterinarian within one week before the animal's initial visit to the facility. The certificate should be updated annually thereafter.

h. Be immediately removed from the premises and taken to the facility's veterinarian if infested with internal or external parasites, vomit, or have diarrhea, or show signs of a behavioral change or infectious disease. Medical records of the veterinarian's diagnosis and treatment should be maintained in the animal's file. The animal should not have patient contact until authorized by the facility's veterinarian.

i. Be housebroken if more than four months of age. Younger dogs may be admitted subject to the requirements of the administrator.

j. Be fed in accordance with the interval and quantity recommended by the facility's veterinarian. Feeding and watering bowls should be washed daily and stored separately from dishes and utensils used for human consumption.

k. Be provided fresh water daily and have 24–hour access to the water dish.

l. Be provided a suitable bedding area. Bedding should be cleaned or changed as needed. Dirty bedding should be processed or disposed of as necessary.

m. Be permitted outside the facility only if under the supervision of a staff member, a responsible person or within a fenced area.

n. Be regularly groomed and receive a bath whenever indicated.

2. Residential birds:

a. Should be treated by a licensed veterinarian with an approved chlortetracycline treatment regimen prior to being housed at the institution to ensure the absence of psittacosis. The period of treatment varies between 30 to 45 days and is species-dependent. A signed statement from the veterinarian indicating such treatment should be kept in the bird's file.

b. That die, or are suspected of having psittacosis, should be immediately taken to the facility's veterinarian. In the event the bird dies and the veterinarian is not available, the bird's body should be securely wrapped in impermeable wrapping material and frozen until veterinary consultation is available.

3. Residential hamsters, gerbils, guinea pigs, domestic rabbits, laboratory mice or rats should be examined yearly by a licensed veterinarian for health status. A health certificate should be completed for each animal or group of animals. Any animal which becomes sick or dies should be promptly taken to the facility's veterinarian.

APPENDIX B

GUIDELINE FOR THE MANAGEMENT OF INAPPROPRIATE BEHAVIOR AND RESIDENT TO RESIDENT ABUSE

I. The initial resident assessment should include a psychosocial behavior component with interventions, if appropriate, in the care plan. Reassessment should be done at least quarterly, or at any time when a resident's pattern of behavior changes. Resident response to interventions should be recorded in the medical record.

II. Inappropriate behavior and/or actions should trigger an immediate reassessment with adjusted interventions; notification of the physician and/or the designated resident representative. Resident response should be recorded in the medical record. The facility's actions/interventions in response to behavior changes should also be part of the plan of care and should be appropriately recorded. Prompt reassessment of behavioral changes will in most cases avert the continued progression of inappropriate behavior.

III. Inappropriate behavior and/or actions involving other residents should be identified in the records of all involved residents including assessments, interventions and responses. Notifications of physician and/or designated resident representatives should also be recorded in medical records of all involved residents.

IV. Incidents of inappropriate behavior or actions of abuse between residents should result in the following actions, as applicable:

A. Immediate assessments of involved residents.

B. Notification of attending physicians.

C. Interventions and responses of residents.

D. Notification of residents' designated representatives.

E. Protection of involved residents' civil and constitutional rights.

F. Determination by administrator of facility's ability to assure safety and security of all patients.

G. Implementation of emergency or short-term precautions to assure safety while working toward resolution.

H. Notification of police if necessary.

V. In the event that it is determined that a resident must be removed from the facility, the transfer should be initiated in accordance with the provisions of this chapter.

VI. Transfer from the facility should be based on the appropriate evaluation and transfer order of the attending physician, facility medical director and/or consultant psychiatrist.

VII. In the event of an immediate emergency situation only:

1. Have patient removed to emergency room of local hospital for medical and/or psychiatric evaluation and consultation by a physician. Return of patient to the long term care facility should be based on the physician's written notation of the appropriateness of returning the resident to the long term care setting. The administrator is responsible for the decision to accept or deny the return of the resident according to N.J.A.C. 8:39.

2. A police complaint should be filed against the abuser and have the individual removed. The complaint can be filed by the facility or the abused party.

3. Notify all agencies (i.e., Medicaid if applicable, Ombudsman for the Institutionalized Elderly, if applicable (over 60) and the Department of Health.)

VIII. In the event all guidelines have been followed and resolution has not taken place, assistance should be requested from the Health Department.

IX. Facility policies and procedures to address inappropriate resident behavior, including resident to resident abuse, should include all of the above outlined actions.

X. To determine resident's emotional adjustment to the nursing facility, including his/her general attitude, adaptation to surroundings, and change in relationship patterns, the following areas should be evaluated:

1. Sense of Initiative/Involvement

Intent: To assess degree to which the resident is involved in the life of the nursing home and takes initiative in activities.

Process: Selected responses should be confirmed by the resident's behavior (either verbal or nonverbal) over the past seven days. The primary source of information is the resident. Secondarily, staff members who have regular contact with the resident should be consulted (e.g., nursing assistants, activities personnel, social work staff, or therapists if the person receives active rehabilitation). Also, consider how resident's cultural standards affect the level of initiative or involvement.

Definition: At ease interacting with others—Consider how resident behaves during time you are together, as well as reports of how resident behaves with other residents, staff, and visitors. Does resident try to shield himself/herself from being with others? Does he/she spend most time alone? How does he/she behave when visited?

At ease doing planned or structured activities—Consider how resident responds to such activities. Does he/she feel comfortable with the structure or restricted by it? *[Note: The item on the MDS form was inadvertently referred to as "structural" activities.]*

At ease with self-initiated activities—These include leisure activities (e.g., reading, watching TV, talking with friends), and work activities (e.g., folding personal laundry, organizing belongings). Does resident spend most of his/her time alone, or does resident always look for someone to find something for him/her to do?

Establishes his/her own goals—Consider statements resident makes like, "I hope I am able to walk again," or "I would like to get up early and visit the beauty parlor." Goals can be as traditional as wanting to learn how to walk again following a hip replacement, or wanting to live to say goodbye to a loved one. Some things may not be stated verbally, as when resident is observed to have a personal way of living at the facility (e.g., organizing own activities or setting own pace).

Involvement in life of the facility—Consider whether resident partakes of facility events, socializes with peers, discusses activities.

Resident accepts invitations into most group activities—Is resident willing to try group activities even if later, deciding the activity is not suitable and leaving? Does resident regularly refuse to attend group programs?

2. Unsettled Relationships

Intent: To indicate the quality and nature of the resident's interpersonal contacts (i.e., how resident interacts with staff members, family, and other residents).

Process: During routine nursing care activities, observe how the resident interacts with staff members and with other residents. Do you see signs of conflict? Talk with direct-care staff (e.g., nursing assistants, dietary aides who assist in the dining room, social work staff, or activities aides) and ask for their observations of behavior that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that the staff members describing these relationships may be biased.

Definition: Covert/open conflict with and/or repeated criticism of staff—Resident chronically complains about some staff members to other staff members; resident verbally criticizes staff members in therapeutic group situations, causing disruption within the group; or resident constantly disagrees with routines of daily living. *[Note: Checking this item does not require any assumption about why the problem exists or how it could be remedied.]*

Unhappiness with roommate—Includes frequent requests for roommate changes, grumbling about roommate spending too long in the bathroom, or complaints about roommate rummaging in another's belongings.

Unhappiness with residents other than roommate—Includes chronic complaints about the behaviors of others, poor quality of interaction with other residents, lack of peers for socialization. This refers to conflict or disagreement outside of the range of normal criticisms or requests (i.e., beyond a reasonable level).

Openly expresses conflict/anger with family or close friends—Includes expressions of feelings of abandonment, ungratefulness, lack of understanding, or hostility regarding relationships with family/friends.

Absence of personal contact with family/friends—Absence of visitors or telephone calls from significant others in the last seven days.

Recent loss of close family member/friend—Includes relocation of family member/friend to a more distant location, even temporarily (e.g., for the winter months); incapacitation or death of a significant other; a significant relationship that recently ceased.

3. Past Roles

Intent: To indicate recognition or acceptance of feelings regarding role or status now that the person is in the nursing home.

Definition: Strong identification with past roles and life status—This may be indicated, for example, when resident enjoys telling stories about own past; or takes pride in past accomplishments or family life; or prefers to be connected with prior lifestyle (e.g., celebrating family events, carrying on life-long traditions).

Expresses sadness/anger/empty feelings over lost roles/status—Resident expresses feelings such as "I'm not the man I used to be" or "I wish I had been a better mother to my children" or "It's no use; I'm not capable of doing the things I always liked to do." Resident cries when reminiscing about past accomplishments. Be careful not to take the reaction out of context. *For the response to apply, the resident should repeat these concerns or initiate these topics.*

Process: Discuss past life with resident. Use environmental cues to prompt discussions (e.g., family photos, grandchildren's letters or artwork). This information may emerge from discussions around other MDS topics (e.g., Customary Routine, Activity Pursuits, ADLs). Direct-care staff may also have useful insights relevant to these items.

XI. To determine resident's mood and behavior patterns, the following elements should be considered:

1. Sad or Anxious Mood

Intent: To identify the presence of behaviors that may be interpreted as physical or verbal expressions of sadness or anxiety.

Definition: A distressed mood characterized by explicit verbal or gestural expressions of feeling depressed or anxious (or a synonym such as feeling sad, miserable, blue, hopeless, empty, or tearful). This may be a disorder of mood which is usually, but not always, accompanied by a painful mood of such magnitude that it calls for relief because it is severely, or unnecessarily, distressing or threatening to physical health and life, or interferes with functional performance and adaptation. These symptoms may be preceded by anger or withdrawal.

Process: Determine if resident expressed signs of a sad or anxious mood over the past 30 days. *Draw on your own interactions with the resident. Pay particular attention to statements of direct-care staff, social workers, and licensed personnel who may have evaluated the resident in this area. Does the resident cry or look dejected (unhappy) when no one is talking with him/her? When you talk with the resident, does he/she sound hopeless, fearful, sad, anxious? Does the resident report feelings of worthlessness, guilt? Does the resident appear withdrawn, apathetic, without emotion?*

If you are unsure, seek confirming information from others who regularly come in contact with the resident (e.g., activities professionals, social workers, or family members).

2. Mood Persistence

Intent: To identify a persistent sad/anxious mood that has existed on each day *over the last seven days* and was not easily altered by attempts to "cheer up" the resident.

Process: Normally, these moods apply to one or more of the indicators mentioned above of sad/anxious mood.

3. Problem Behavior

Intent: To identify the presence of problem behaviors in the last seven days *that cause disruption to facility residents or staff members, including those that are potentially harmful to the resident or disruptive in the environment, even though staff and residents appear to have adjusted to them (e.g., "Mrs. R's calling out isn't much different than others on the unit; there are many noisy residents.")*

Definition: Wandering—Movement with no identified rational purpose; resident appears oblivious to needs or safety. *This behavior must be differentiated from purposeful movement—e.g., a hungry person moving about the unit in search of food; pacing.*

Report on the most disruptive resident behavior across all three shifts. Code "1" if the described behavior occurred less than daily and "2" if the behavior occurred daily or more frequently.

4. Resident Resists Care

Intent: Identify problem behaviors related to delivering care/treatment to the resident. These behaviors are not necessarily positive or negative; they provide observational data. They may prompt further investigation of causes in the care-planning process (e.g., fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness to participate in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Consult medical record and primary staff caregiver. How does the resident respond to staff members' attempts to deliver care to him/her? Signs of resistance may be verbal and/or physical (e.g., verbally refusing care, pushing caregiver away, scratching).

5. Behavior Management Program

Intent: Determine if a behavior-management program is in place wherein staff members identified causal factors and developed a plan of action based on that understanding. There must be evidence of structure and continuity of care in the program (e.g., written documentation). This category does NOT include behavioral management by physical restraints or psychoactive drugs, if these are the only interventions used.

Process: Consult medical record (including current care plan); consult primary caregiver.

Examples

- Mrs. S has been observed on numerous occasions to hit, shove, and curse the woman seated next to her at each meal. After observing the pattern of Mrs. S's behavior for several days, staff noticed that her tablemate was in the habit of moving toward Mrs. S to take food from her tray. As a result of their observations, the primary nurse made a change in seating arrangements. [Note: Although staff might have increased the amount of food provided at meals, the real issue was the taking of food; Mrs. S would not want to share with others, no matter how much food she was given.] Mrs. S does not tend to ask staff for help when she is annoyed; she takes direct and aggressive action on her own. Now that staff understand this behavior, they are aware of the need to be vigilant. Code "1" for Yes.
- Provisions were made for safely monitored wandering for Mr. V (including use of "secure bands" that activate an alarm if he wanders away from a designated area). Mr. V does not really disturb others (he does not go into others' rooms). Without this "band," however, staff lost track of him and he was in danger of harming himself if he got off the unit (a busy street is very near his unit). Code "1" for Yes.

6. Change in Mood

Intent: Determine whether the resident's mood changed in the *past 90 days,* i.e., onset of recent mood problem or changes in a long-standing problem. Changes may have been expressed verbally or demonstrated physically; they include increased/decreased number of signs/symptoms, or increase/decrease in the frequency, intensity, or persistence of sad or anxious mood.

Examples

- Mrs. D has a long history of depression. Two months ago she had an adverse reaction to a psychoactive drug. She expressed fears that she was going out of her mind and was observed to be quite agitated. Her attention span diminished and she stopped attending group activities because she was disruptive. After the medication was discontinued, these feelings and behaviors improved. She is better than she was, but still has feelings of sadness. Code "1" for "Improved." Mrs. D is now better than her worst status in the 90–day period, but she has not fully

recovered. [Note: If the mood problem was no longer present due to the continued efficacy of the treatment program, the correct code would also be "1" (Improved).]

- Mrs. Y has bipolar disease. Historically, she has responded well to lithium and her mood state has been stable for almost a year. About 2 months ago, she became extremely sad and withdrawn, expressed the wish that she were dead, and stopped eating. She was transferred to a psychiatric hospital. For the last 30 days (following readmission), Mrs. Y has improved and her appetite is restored. Code "1" for Improved.

7. Change in Problem Behavior

Intent: Determine if problem behaviors or resistance to care increased/decreased in number, frequency, or intensity in the *past 90 days*—i.e., onset of recent behavior problems or changes in a more longstanding problem.

Changes can occur in many different areas, including (but not limited to) wandering, verbal or physical abuse, socially inappropriate behavior, or resistance to care. Changes can be exhibited as increases/decreases in the number of signs/symptoms and/or change in the frequency or intensity of the behavior(s).

Process: Review nursing notes, medical records, and consult with primary staff caregiver.

APPENDIX C

WHITE-COPY to accompany patient.
YELLOW COPY FOR institution's file.

HOSPITAL AND NURSING HOME
PATIENT TRANSFER FORM AND PLAN OF CARE

This form has been adopted by the Boards of Trustees of the N.J. Hospital Association and N.J. Assn. of Health Care Facilities

USE REVERSE SIDE IF NECESSARY (PROVIDE COPY)

Last First Middle

Name_____

Address_____

_____

Social Security No._____ S M W D

M/Care #_____ M/Caid #_____

Other Insurance _____

Birth Date _____ Sex _____ Religion _____

Relative or Sponsor _____ Relationship

Address _____

_____

Home Phone _____ Business Phone _____

STATUS: ☐ Private ☐ Medicare ☐ Medicaid ☐ Undetermined ☐ Short Term ☐ Long Term ☐ Undetermined

TRANSFERRED FROM:

_____

Date Admitted _____ Date Discharged _____

TRANSFERRED TO:

_____

Date Admitted _____

Physician in Charge at Time of Transfer _____

_____ M.D

Address _____

_____ Phone No _____

Will this physician care for patient after transfer? _____

DISCHARGE DIAGNOSIS _____

Other Diagnosis _____ Infections: _____ Resolved ☐

Surgery Date _____ Surgery Type _____

VITAL SIGNS T _____ P _____ R _____ BP _____ HT _____ WT _____ Allergies _____

DIET, DRUGS AND OTHER THERAPY At Time of Discharge (include time of last medication dose or treatment)

_____

SOCIAL INFORMATION (include reason for transfer)

Has patient made any advance directives (living will/durable power of attorney)? ☐ Yes ☐ No Copy attached ☐ Yes ☐ No
Does patient have DNR orders? ☐ Yes ☐ No Copy attached ☐ Yes ☐ No

PLAN OF CARE AT TIME OF DISCHARGE

BEHAVIOR	ASSISTIVE DEVICES	IMPAIRMENTS	CATHETERS/TUBES/ DRAINS	DATE LAST CHANGED	FUNCTIONAL STATUS
☐ Alert	☐ Dentures ☐ P	☐ Speech	☐ Foley	_____	☐ Ambulation (independent or w/assist.)
☐ Forgetful	☐ Glasses	☐ Vision	☐ N/G	_____	☐ Bed to Chair
☐ Confused	☐ Hearing Aid	☐ Hearing	☐ Gastric	_____	☐ Bedfast
☐ Wanders	☐ Prosthesis	☐ Sensation	☐ Other _____	_____	☐ Restraint and type _____
☐ Combative	☐ Pacemaker	ELIMINATION			☐ Physical Therapy (describe modality)
☐ Noisy	☐ Other _____	☐ Continent			_____
☐ Comatose (Semi)		☐ Incontinent (Bladder/Bowel)	Date Last Enema/BM _____		_____

SPECIAL CARE & EQUIPMENT

Decubiti/Wound _____

_____

_____

Other _____

_____

FACILITY CONTACT PERSON _____ TEL. NO. _____

I CERTIFY this patient requires the following level of care. ☐ SNF ☐ NF ☐ RHCF PHYSICIAN _____ DATE _____
(Signature required)

NOTE ATTACH LAB, X-RAY AND OTHER SIGNIFICANT REPORTS

APPENDIX D

MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)
BACKGROUND INFORMATION/INTAKE AT ADMISSION

I. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	(First) (Middle Initial) (Last)
2.	DATE OF CURRENT ADMISSION	Month Day Year
3.	MEDICARE NO (SOC. SEC. or Comparable No. if no Medicare No.)	
4.	FACILITY PROVIDER NO	Federal No
5.	GENDER	1. Male 2. Female
6.	RACE/ ETHNICITY	1. American Indian/Alaska Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
7.	BIRTHDATE	Month Day Year
8.	LIFETIME OCCUPATION	
9.	PRIMARY LANGUAGE	Resident's primary language is a language other than English. 0. No 1. Yes _____ (Specify)
10.	RESIDENTIAL HISTORY PAST 5 YEARS	*(Check all settings resident lived in during 5 years prior to admission)* Prior stay at this nursing home; Other nursing home/residential facility; MH/psychiatric setting; MR/DD setting; *NONE OF ABOVE*
11.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or any other mental health problem? 0. No 1. Yes
12.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status, that were manifested before age 22, and are likely to continue indefinitely)* Not applicable—no MR/DD (Skip to Item 13); MR/DD with Organic Condition: Cerebral palsy; Down's syndrome; Autism; Epilepsy; Other organic condition related to MR/DD; MR/DD with no organic condition; Unknown
13.	MARITAL STATUS	1. Never Married 2. Married 3. Widowed 4. Separated 5. Divorced
14.	ADMITTED FROM	1. Private home or apt. 2. Nursing home 3. Acute care hospital 4. Other
15.	LIVED ALONE	0. No 1. Yes 2. In other facility
16.	ADMISSION INFORMATION AMENDED	*(Check all that apply)* Accurate information unavailable earlier; Observation revealed additional information; Resident unstable at admission

II. BACKGROUND INFORMATION AT RETURN/READMISSION

1.	DATE OF CURRENT READMISSION	Month Day Year
2.	MARITAL STATUS	1 Never Married 2 Married 3 Widowed 4 Separated 5 Divorced
3.	ADMITTED FROM	1 Private home or apt. 2 Nursing home 3 Acute care hospital 4 Other
4.	LIVED ALONE	0. No 1. Yes 2. In other facility
5.	ADMISSION INFORMATION AMENDED	*(Check all that apply)* Accurate information unavailable earlier; Observation revealed additional information; Resident unstable at admission

III. CUSTOMARY ROUTINE (ONLY AT FIRST ADMISSION)

1.	CUSTOMARY ROUTINE (Year prior to first admission to a nursing home)	*(Check all that apply. If all information UNKNOWN, check last box only.)*
	CYCLE OF DAILY EVENTS	Stays up late at night (e.g., after 9 pm); Naps regularly during day (at least 1 hour); Goes out 1+ days a week; Stays busy with hobbies, reading, or fixed daily routine; Spends most time alone or watching TV; Moves independently indoors (with appliances, if used); *NONE OF ABOVE*
	EATING PATTERNS	Distinct food preferences; Eats between meals all or most days; Use of alcoholic beverage(s) at least weekly; *NONE OF ABOVE*
	ADL PATTERNS	In bed/clothes much of day; Wakens to toilet all or most nights; Has irregular bowel movement pattern; Prefers showers for bathing; *NONE OF ABOVE*
	INVOLVEMENT PATTERNS	Daily contact with relatives/close friends; Usually attends church, temple, synagogue (etc.); Finds strength in faith; Daily animal companion/presence; Involved in group activities; *NONE OF ABOVE*
		UNKNOWN—Resident/family unable to provide information

END

Signature of RN Assessment Coordinator: _____

Signatures of Others Who Completed Part of the Assessment:

MINIMUM DATA SET FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING (MDS)
(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. ASSESSMENT DATE — Month / Day / Year
2. RESIDENT NAME — (First) (Middle Initial) (Last)
3. SOCIAL SECURITY NO.
4. MEDICAID NO. (If applicable)
5. MEDICAL RECORD NO.
6. REASON FOR ASSESSMENT
1. Initial admission assess
2. Hosp/Medicare reassess
3. Readmission assessment
4. Annual assessment
5. Significant change in status
6. Other (e.g., UR)
7. CURRENT PAYMENT SOURCE(S) FOR N.H. STAY (Billing Office to indicate: check all that apply)
a. Medicaid
b. Medicare
c. CHAMPUS
d. VA
e. Self pay/Private insurance
f. Other
8. RESPONSIBILITY/ LEGAL GUARDIAN (Check all that apply)
a. Legal guardian
b. Other legal oversight
c. Durable power attny / health care proxy
d. Family member responsible
e. Resident responsible
f. NONE OF ABOVE
9. ADVANCED DIRECTIVES (For those items with supporting documentation in the medical record, check all that apply)
a. Living will
b. Do not resuscitate
c. Do not hospitalize
d. Organ donation
e. Autopsy request
f. Feeding restrictions
g. Medication restrictions
h. Other treatment restrictions
i. NONE OF ABOVE
10. DISCHARGE PLANNED WITHIN 3 MOS. (Does not include discharge due to death)
0. No 1. Yes 2. Unknown/uncertain
11. PARTICIPATE IN ASSESSMENT
a. Resident: 0. No 1. Yes
b. Family: 0. No 1. Yes 2. No family
12. SIGNATURES
Signature of RN Assessment Coordinator
Signatures of Others Who Completed Part of the Assessment:

SECTION B. COGNITIVE PATTERNS

1. COMATOSE (Persistent vegetative state/no discernible consciousness)
0. No 1. Yes (Skip to SECTION E)
2. MEMORY (Recall of what was learned or known)
a. Short-term memory OK—seems/appears to recall after 5 minutes: 0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past: 0. Memory OK 1. Memory problem
3. MEMORY/ RECALL ABILITY (Check all that resident normally able to recall during last 7 days)
a. Current season
b. Location of own room
c. Staff names/faces
d. That he/she is in a nursing home
e. NONE OF ABOVE are recalled

= Code the appropriate response ☐ = Check all the responses that apply

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (Made decisions regarding tasks of daily life)
0. Independent—decisions consistent/reasonable
1. Modified independence—some difficulty in new situations only
2. Moderately impaired—decisions poor; cues/supervision required
3. Severely impaired—never/rarely made decisions
5. INDICATORS OF DELIRIUM —PERIODIC DISORDERED THINKING/ AWARENESS (Check if condition over last 7 days appears different from usual functioning)
a. Less alert, easily distracted
b. Changing awareness of environment
c. Episodes of incoherent speech
d. Periods of motor restlessness or lethargy
e. Cognitive ability varies over course of day
f. NONE OF ABOVE
6. CHANGE IN COGNITIVE STATUS Change in resident's cognitive status, skills, or abilities in last 90 days
0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING (With hearing appliance, if used)
0. Hears adequately—normal talk, TV, phone
1. Minimal difficulty when not in quiet setting
2. Hears in special situations only—speaker has to adjust tonal quality and speak distinctly
3. Highly impaired/absence of useful hearing
2. COMMUNICATION DEVICES/ TECHNIQUES (Check all that apply during last 7 days)
a. Hearing aid, present and used
b. Hearing aid, present and not used
c. Other receptive comm. techniques used (e.g., lip read)
d. NONE OF ABOVE
3. MODES OF EXPRESSION (Check all used by resident to make needs known)
a. Speech
b. Writing messages to express or clarify needs
c. Signs/gestures/sounds
d. Communication board
e. Other
f. NONE OF ABOVE
4. MAKING SELF UNDERSTOOD (Expresses information content—however able)
0. Understood
1. Usually understood—difficulty finding words or finishing thoughts
2. Sometimes understood—ability is limited to making concrete requests
3. Rarely/Never understood
5. ABILITY TO UNDERSTAND OTHERS (Understanding verbal information content—however able)
0. Understands
1. Usually understands—may miss some part/intent of message
2. Sometimes understands—responds adequately to simple, direct communication
3. Rarely/Never understands
6. CHANGE IN COMMUNICATION/ HEARING Resident's ability to express, understand or hear information has changed over last 90 days
0. No change 1. Improved 2. Deteriorated

SECTION D. VISION PATTERNS

1. VISION (Ability to see in adequate light and with glasses if used)
0. Adequate—sees fine detail, including regular print in newspapers/books
1. Impaired—sees large print, but not regular print in newspapers/books
2. Highly impaired—limited vision; not able to see newspaper headlines; appears to follow objects with eyes
3. Severely impaired—no vision or appears to see only light, color, or shapes
2. VISUAL LIMITATIONS/ DIFFICULTIES Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)
a. Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes
b. NONE OF ABOVE
3. VISUAL APPLIANCES Glasses; contact lenses, lens implants; magnifying glass
0. No 1. Yes

SECTION E. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. ADL SELF-PERFORMANCE — *(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)*

0. *INDEPENDENT* — No help or oversight — OR — Help/oversight provided only 1 or 2 times during last 7 days
1. *SUPERVISION* — Oversight, encouragement or cueing provided 3+ times during last 7 days — OR — Supervision plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE* — Resident highly involved in activity, received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3+ times — OR — More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE* — While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times
   — Weight-bearing support
   — Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE* — Full staff performance of activity during entire 7 days

2. ADL SUPPORT PROVIDED — *(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist

			(1) SELF-PERF	(2) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	LOCO-MOTION	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
d.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
e.	EATING	How resident eats and drinks (regardless of skill)		
f.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
h.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair. *Code for most dependent in self-performance and support.* Bathing Self-Performance codes appear below)		

0. Independent—No help provided
1. Supervision—Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence

4. BODY CONTROL PROBLEMS *(Check all that apply during last 7 days)*

Balance—partial or total loss of ability to balance self while standing	a.	Hand—lack of dexterity (e.g., problem using toothbrush or adjusting hearing aid)	g.
Bedfast all or most of the time	b.	Leg—partial or total loss of voluntary movement	h.
Contracture to arms, legs, shoulders, or hands	c.	Leg—unsteady gait	i.
Hemiplegia/hemiparesis	d.	Trunk—partial or total loss of ability to position, balance, or turn body	j.
Quadriplegia	e.		
Arm—partial or total loss of voluntary movement	f.	Ambulation	k.
		NONE OF ABOVE	l.

5. MOBILITY APPLIANCES/DEVICES *(Check all that apply during last 7 days)*

Cane/walker	a.	Other person wheeled	d.
Brace/prosthesis	b.	Lifted (manually/mechanically)	e.
Wheeled self	c.	NONE OF ABOVE	f.

6. TASK SEGMENTATION — Resident requires that some or all of ADL activities be broken into a series of subtasks so that resident can perform them. 0. No 1. Yes

7. ADL FUNCTIONAL REHABILITATION POTENTIAL

- Resident believes he/she capable of increased independence in at least some ADLs — a.
- Direct care staff believe resident capable of increased independence in at least some ADLs — b.
- Resident able to perform task/activity but is very slow — c.
- Major difference in ADL Self-Performance or ADL Support in mornings and evenings (at least a one category change in Self-Performance or Support in any ADL) — d.
- NONE OF ABOVE — e.

8. CHANGE IN ADL FUNCTION — Change in ADL self-performance in last 90 days. 0. No change 1. Improved 2. Deteriorated

SECTION F. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES *(Code for resident performance over all shifts)*

0. CONTINENT — Complete control
1. USUALLY CONTINENT — BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. OCCASIONALLY INCONTINENT — BLADDER, 2+ times a week but not daily; BOWEL, once a week
3. FREQUENTLY INCONTINENT — BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. INCONTINENT — Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	

2. INCONTINENCE RELATED TESTING

(Skip if resident's bladder continence code equals 0 or 1 AND no catheter is used)

- Resident has been tested for a urinary tract infection — a.
- Resident has been checked for presence of a fecal impaction, or there is adequate bowel elimination — b.
- NONE OF ABOVE — c.

3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan	a.	Pads/shields used	f.
External (condom) catheter	b.	Enemas/irrigation	g.
Indwelling catheter	c.	Ostomy	h.
Intermittent catheter	d.	NONE OF ABOVE	i.
Did not use toilet room/commode/urinal	e.		

4. CHANGE IN URINARY CONTINENCE — Change in urinary continence/appliances and programs in last 90 days. 0. No change 1. Improved 2. Deteriorated

SECTION G. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/INVOLVEMENT

- At ease interacting with others — a.
- At ease doing planned or structural activities — b.
- At ease doing self-initiated activities — c.
- Establishes own goals — d.
- Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) — e.
- Accepts invitations into most group activities — f.
- NONE OF ABOVE — g.

2. UNSETTLED RELATIONSHIPS

- Conflict/open conflict and/or repeated criticism of staff — a.
- Unhappy with roommate — b.
- Unhappy with residents other than roommate — c.
- Openly expresses conflict/anger with family or friends — d.
- Absence of personal contact with family/friends — e.
- Recent loss of close family member/friend — f.
- NONE OF ABOVE — g.

3. PAST ROLES

- Strong identification with past roles and life status — a.
- Expresses sadness/anger/empty feeling over lost roles/status — b.
- NONE OF ABOVE — c.

SECTION H. MOOD AND BEHAVIOR PATTERNS

1.	SAD OR ANXIOUS MOOD	*(Check all that apply during last 30 days)*	
		VERBAL EXPRESSIONS of DISTRESS by resident (sadness, sense that nothing matters, hopelessness, worthlessness, unrealistic fears, vocal expressions of anxiety or grief)	a.
		DEMONSTRATED (OBSERVABLE) SIGNS of mental DISTRESS	
		— Tearfulness, emotional crying, sighing, breathlessness	b.
		— Motor agitation such as pacing, handwringing or picking	c.
		— Failure to eat or take medications, withdrawal from self-care or leisure activities	d.
		— Pervasive concern with health	e.
		— Recurrent thoughts of death—e.g., believes he/she about to die, have a heart attack	f.
		— Suicidal thoughts/actions	g.
		NONE OF ABOVE	h.
2.	MOOD PERSISTENCE	Sad or anxious mood includes on daily life over last 7 days — not easily altered, doesn't "cheer up" 0. No 1. Yes	
3.	PROBLEM BEHAVIOR	*(Code for behavior in last 7 days)* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently	
		WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	a.
		VERBALLY ABUSIVE (others were threatened, screamed at, cursed at)	b.
		PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused)	c.
		SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	d.
4.	RESIDENT RESISTS CARE	*(Check all types of resistance that occurred in the last 7 days)*	
		Resisted taking medications/injection	a.
		Resisted ADL assistance	b.
		NONE OF ABOVE	c.
5.	BEHAVIOR MANAGEMENT PROGRAM	Behavior problem has been addressed by clinically developed behavior management program. (Note: Do not include programs that involve any physical restraints or psychotropic medications in this category) 0. No behavior problem 1. Yes, addressed 2. No, not addressed	
6.	CHANGE IN MOOD	Change in mood in last 90 days 0. No change 1. Improved 2. Deteriorated	
7.	CHANGE IN PROBLEM BEHAVIOR	Change in problem behavioral signs in last 90 days 0. No change 1. Improved 2. Deteriorated	

SECTION I. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	NONE OF ABOVE	d.
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	0. Most—more than 2/3 of time 1. Some—1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None			
3.	PREFERRED ACTIVITY SETTINGS	*(Check all settings in which activities are preferred)*			
		Own room	a.	Outside facility	d.
		Day/activity room	c.	NONE OF ABOVE	e.
		Inside NH/off unit	c.		

4.	GENERAL ACTIVITY PREFERENCES (adequate to resident's current abilities)	*(Check all PREFERENCES whether or not activity is currently available to resident)*			
		Cards/other games	a.	Spiritual/religious activities	f.
		Crafts/arts	b.	Trips/shopping	g.
		Exercise/sports	c.	Walking/wheeling outdoors	h.
		Music	d.	Watch TV	i.
		Reading	e.	NONE OF ABOVE	j.
5.	PREFERS MORE OR DIFFERENT ACTIVITIES	Resident expresses/indicates preference for other activities/ choices 0. No 1. Yes			

SECTION J. DISEASE DIAGNOSES

Check only those diseases present that have a relationship to current ADL status, cognitive status, behavior status, medical treatments, or risk of death. (Do not list old/ inactive diagnoses.)

1.	DISEASES	*(If none apply, CHECK the NONE OF ABOVE box)*			
		HEART/CIRCULATION		PSYCHIATRIC/MOOD	
		Arteriosclerotic heart disease (ASHD)	a.	Anxiety disorder	p.
		Cardiac dysrhythmias	b.	Depression	q.
		Congestive heart failure	c.	Manic depressive (bipolar disease)	r.
		Hypertension	d.	SENSORY	
		Hypotension	e.	Cataracts	s.
		Peripheral vascular disease	f.	Glaucoma	t.
		Other cardiovascular disease	g.	OTHER	
		NEUROLOGICAL		Allergies	u.
		Alzheimer's	h.	Anemia	v.
		Dementia other than Alzheimer's	i.	Arthritis	w.
		Aphasia	j.	Cancer	x.
		Cerebrovascular accident (stroke)	k.	Diabetes mellitus	y.
		Multiple sclerosis	l.	Explicit terminal prognosis	z.
		Parkinson's disease	m.	Hypothyroidism	aa.
		PULMONARY		Osteoporosis	bb.
		Emphysema/Asthma/ COPD	n.	Seizure disorder	cc.
		Pneumonia	o.	Sepsis/me	dd.
				Urinary tract infection—in last 30 days	ee.
				NONE OF ABOVE	ff.
2.	OTHER CURRENT DIAGNOSES AND ICD-9 CODES	a.			
		b.			
		c.			
		d.			
		e.			
		f.			

SECTION K. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	*(Check all problems that are present in last 7 days unless other time frame indicated)*			
		Constipation	a.	Pain—resident complains or shows evidence of pain daily or almost daily	j.
		Diarrhea	b.		
		Dizziness/vertigo	c.	Recurrent lung aspirations in last 90 days	k.
		Edema	d.	Shortness of breath	l.
		Fecal impaction	e.	Syncope (fainting)	m.
		Fever	f.	Vomiting	n.
		Hallucinations/ delusions	g.	NONE OF ABOVE	o.
		Internal bleeding	h.		
		Joint pain	i.		
2.	ACCIDENTS	Fell in past 30 days	a.	Hip fracture in last 180 days	c.
		Fell in past 31-180 days	b.	NONE OF ABOVE	d.

3	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, or behavior status unstable—fluctuating, precarious, or deteriorating	a
		Resident experiencing an acute episode or a flare-up of a recurrent/chronic problem	b
		NONE OF ABOVE	c

SECTION L. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem	a.
		Swallowing problem	b.
		Mouth pain	c.
		NONE OF ABOVE	d
2.	HEIGHT AND WEIGHT	*Record height (a.) in inches and weight (b.) in pounds. Weight based on most recent status in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* HT (in.) a. WT (lb.) b.	
		c. Weight loss (i.e., 5%+ in last 30 days; or 10%+ in last 180 days) 0. No 1. Yes	c
3.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods a.	
		Insufficient fluid; dehydrated b.	
		Did NOT consume at/almost all liquids provided during last 3 days c	
		Regular complaint of hunger	d.
		Leaves 25%+ food uneaten at most meals	e.
		NONE OF ABOVE	f.
4.	NUTRITIONAL APPROACHES	Parenteral/IV a.	
		Feeding tube b	
		Mechanically altered diet c.	
		Syringe (oral feeding) d.	
		Therapeutic diet e	
		Dietary supplement between meals	f.
		Plate guard, stabilized built-up utensil, etc.	g.
		NONE OF ABOVE	h.

SECTION M. ORAL/DENTAL STATUS

1	ORAL STATUS AND DISEASE PREVENTION	Dentures (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures and/or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingivia); swollen or bleeding gums; oral abscesses, ulcers or rashes	e
		Daily cleaning of teeth/dentures	f.
		NONE OF ABOVE	g.

SECTION N. SKIN CONDITION

1.	STASIS ULCER	(open lesion caused by poor venous circulation to lower extremities) 0. No 1. Yes	
2.	PRESSURE ULCERS	*(Code for highest stage of pressure ulcer)* 0. No pressure ulcers	
		1. Stage 1 A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved	
		2. Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater	
		3. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue	
		4. Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone	
3	HISTORY OF RESOLVED/CURED PRESSURE ULCERS	Resident has had a pressure ulcer that was resolved/cured in last 90 days 0. No 1. Yes	

4	SKIN PROBLEMS CARE	Open lesions other than stasis or pressure ulcers (e.g., cuts)	a.
		Skin desensitized to pain, pressure, discomfort	b
		Protective/preventive skin care	c
		Turning/repositioning program	d
		Pressure relieving beds, bed/chair pads (e.g., egg crate pads)	e
		Wound care/treatment (e.g., pressure ulcer care, surgical wound)	f
		Other skin care/treatment	g
		NONE OF ABOVE	h

SECTION O. MEDICATION USE

1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*	
2	NEW MEDICATIONS	Resident has received new medications during the last 90 days 0. No 1. Yes	
3	INJECTIONS	*(Record the number of days injections of any type received during the last 7 days)*	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of days during last 7 days; enter "0" if not used; enter "1" if long-acting meds. used less than weekly)* Antipsychotics	a.
		Antianxiety/hypnotics	b.
		Antidepressants	c.
5.	PREVIOUS MEDICATION RESULTS	*(SKIP this question if resident currently receiving antipsychotics, antidepressants, or antianxiety/hypnotics—otherwise code correct response for last 90 days)* Resident has previously received psychoactive medications for a mood or behavior problem, and these medications were effective (without undue adverse consequences) 0. No, drugs not used 1. Drugs were effective 2. Drugs were not effective 3. Drug effectiveness unknown	

SECTION P. SPECIAL TREATMENT AND PROCEDURES

1.	SPECIAL TREATMENTS AND PROCEDURES	SPECIAL CARE—*Check treatments received during the last 14 days*			
		Chemotherapy	a.	IV meds	f.
		Radiation	b.	Transfusions	g.
		Dialysis	c.	O_2	h.
		Suctioning	d.	Other _____	i.
		Trach. care	e	*NONE OF ABOVE*	j.
		THERAPIES—*Record the number of days each of the following therapies was administered (for at least 10 minutes during a day) in the last 7 days.*			
		Speech—language pathology and audiology services			k.
		Occupational therapy			l.
		Physical therapy			m.
		Psychological therapy (any licensed professional)			n.
		Respiratory therapy			o.
2.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90-days? 0. No 1. Yes 2. No tests performed			
3.	DEVICES AND RESTRAINTS	*Use the following codes for last 7 days:* 0. Not used 1. Used less than daily 2. Used daily			
		Bed rails			a.
		Trunk restraint			b.
		Limb restraint			c.
		Chair prevents rising			d.

SECTION Q: RESIDENT CLASSIFICATION

1. Payment Source
   - Private [ ]
   - Medicare [ ]
   - Medicaid [ ]
   - Other _____

2. Requires Basic Nursing Services (See N.J.A.C. 10:63-2A.1(f).) [ ]

3. Requires Additional Nursing Services (See N.J.A.C. 10:63-2A.1(f)4.) as below: [ ]
   - i. Tracheostomy [a]
   - ii. Use of Respirator [b]
   - iii. Head Trauma Stimulation/ advanced neuromuscular/ orthopedic care [c]
   - iv. Intravenous Therapy [d]
   - v. Wound Care [e]
   - vi. Oxygen Therapy [f]
   - vii. Nasogastric tube feeding and/or Gastrostomy [g]

_____ _____ _____
Signature of RN Coordinator License Number Date

Signatures of Others Who Completed Part of the Assessment:

_____ _____
Name Title

_____ _____
Name Title

Resident's Name.	Medical Record No.:

Signature of RN Assessment Coordinator: _____

RESIDENT ASSESSMENT PROTOCOL SUMMARY

1. For each RAP area triggered, show whether you are proceeding with a care plan intervention.
2. Document problems, complications, and risk factors; the need for referral to appropriate health professionals; and the reasons for deciding to proceed or not to proceed to care planning. Documentation may appear anywhere the facility routinely keeps such information, such as problem sheets or nurses' progress notes.
3. Show location of this information.

RAP Problem Area	Care Planning Decision		Location of Information
	Proceed	Not Proceed	
DELIRIUM	☐	☐	
COGNITIVE LOSS/DEMENTIA	☐	☐	
VISUAL FUNCTION	☐	☐	
COMMUNICATION	☐	☐	
ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐	☐	
URINARY INCONTINENCE AND INDWELLING CATHETER	☐	☐	
PSYCHOSOCIAL WELL-BEING	☐	☐	
MOOD STATE	☐	☐	
BEHAVIOR PROBLEM	☐	☐	
ACTIVITIES	☐	☐	
FALLS	☐	☐	
NUTRITIONAL STATUS	☐	☐	
FEEDING TUBES	☐	☐	
DEHYDRATION/FLUID MAINTENANCE	☐	☐	
DENTAL CARE	☐	☐	
PRESSURE ULCERS	☐	☐	
PSYCHOTROPIC DRUG USE	☐	☐	
PHYSICAL RESTRAINTS	☐	☐	

August 15, 1990

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND

LEGEND
● Automatic Trigger—Go directly to RAP instructions
▲ Potential Trigger—Go to RAP instructions for more detailed trigger definitions

Instructions: Match MDS item codes with trigger codes below. Proceed to RAP instructions as indicated by symbol. Circle all RAPs that are "triggered," based on your review.

MDS Item	Code	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL Functional/Rehabilitation Potential	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavior Problem	Activities	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints
B2 a or b	1		▲																
B3 a.b.c.d	fewer than 3 ✓		▲																
B4	0,1,2				▲														
	1,2,3		▲																
B5 a.b.c.d.e	any ✓	●																	
B6	2	●												▲					
C4	2,3				▲														
C5	1,2,3		▲																
	2,3				▲	▲													
C6	2	●																	
D1	1,2,3			●															
D2 a	✓			●															
E1 a.b.c.d.e.l	3,4					▲													
E3 a	3,4					▲													
E4 a.b.d.e.h.j	any ✓										▲								
E7 a.b	any ✓					▲													
E8	2													▲					
F1 b	2,3,4						▲												
F3 b.c.d.l	any ✓						▲												
G2 a.b.c.d	any ✓							●											
G3 b	✓							●											
H1 a.b.c.d.e.(g)	any ✓								●										
H1 d	✓													▲					
H2	:								●										
H3 a.b.c or d	1,2									●									
H6	2	▲																	
H7	2	●																	
I2	0,2,3										▲								
I5	1										●								
J1 ee	✓													▲					
J2	250, 251, 252											●							
	263, 263.0, 263.1											●							
	263.2, 263.8, 263.9											●							
	276.5													▲					
	291.0, 292.81	●																	
	293.0, 293.1	●																	
K1 b.c.l.h.n	any ✓													▲					
K2 a.b	any ✓											●							
L1 c	✓															●			
L2 c	1											●		▲					
L3 a.d.e	any ✓											●							
L3 b	✓													●					
L3 c.e	✓													▲					
L4 a.b	any ✓													▲					
L4 a.c.d.e	any ✓											●							
L4 b	✓												●						
M1 a.c.d.e	any ✓															●			
M1 l	not ✓															●			
N2	1,2,3,4											●					●		
N4 c.d.e.l.o	none ✓																▲		
O4 a.b.c	1-7								▲		▲							▲	
									▲										●

APPENDIX E

GUIDELINES FOR THE USE OF RESTRAINTS

A. Written policies and procedures for use of restraints should address at least the following:

1. Protocol for the use of alternatives to restraints, such as staff or environmental interventions, structured activities, or behavior management. Alternatives should be utilized whenever possible to avoid the use of restraints;
2. Protocol for the use and documentation of a progressive range of restraining procedures from the least restrictive to the most restrictive;
3. A delineation of indications for use, which should be limited to:
   i. Prevention of imminent harm to the resident or other persons when other means of control are not effective or appropriate; or
   ii. Prevention of serious disruption of treatment or significant damage to the physical environment;
4. Contraindications for use, which should include, at least, clinical contraindications, convenience of staff, or discipline of the resident;
5. Identification of restraints which may be used in the facility, which should be limited to methods and mechanical devices that are specifically manufactured for the purpose of physical restraint. Locked restraints, double restraints on the same body part, four-point restraints, and confinement in a locked or barricaded room should not be permitted;
6. Protocol for informing the resident and obtaining consent when clinically feasible, and documenting the consent in the resident's record;
7. Protocol for notifying the family or guardian, obtaining consent if the resident is unable to give consent, and documenting the consent in the resident's record;
8. Protocol for removal of restraints when goals have been accomplished.

B. Procedures for the application of restraints in an emergency should include at least the following:

1. Licensed nursing staff only should initiate the use of emergency restraints;
2. The application of restraints should begin with the least restrictive alternative that is clinically feasible;
3. Emergency restraints should be used only when the safety of the resident or others is endangered, or there is imminent risk that the resident will cause substantial damage to the physical environment;
4. The facility should notify the attending physician or another designated physician and request an order within two hours;
5. The facility should obtain a physician's order within eight hours;
6. Licensed nursing personnel should evaluate and document the physical and mental condition of the resident in emergency restraints at least every two hours;
7. There should be an assessment of the resident by a registered professional nurse within 24 hours; and
8. Continuation of emergency restraints should occur only upon physician orders, which should be renewed every 24 hours to a maximum of seven days.

C. The facility should continuously attempt to remediate the resident's condition to eliminate or lessen the need for restraints. If the use of restraints is needed beyond one week, at least the following should be done:

1. The need for the continued use of restraints should be implemented only as part of the physician's medical care plan; and
2. Every resident in restraints should be assessed by a registered professional nurse at least every 48 hours for the continued use of restraints; and
3. After remediation attempts, there should be an interdisciplinary review of the record of any resident whose assessment indicates the need for continued use of restraints. This review should occur within thirty days of the initiation of the use of restraints.

D. Continuation of the use of restraints beyond 30 days should occur only upon written approval of the committee or its equivalent, and should include at least the following actions:

1. The registered professional nurse should assess the need for continued restraints at least weekly; and
2. An interdisciplinary review should be conducted at least every 30 days to approve the continued use of restraints.

E. The facility should have written policies and procedures to ensure that interventions while a resident is restrained, except as indicated in F below, are performed by nursing personnel in accordance with nursing scope of practice as set forth by the New Jersey Board of Nursing. The policies and procedures should include at least the following:

1. Periodic visual observation, which should be performed with the following frequency:
   i. Continuously, if clinically indicated by the resident's condition; or
   ii. At least every 15 minutes while the resident's condition is unstable; and thereafter at least every one to two hours, based upon an assessment of the resident's condition.
2. Release of restraints at least once every two hours in order to:
   i. Assess circulation;
   ii. Perform skin care;
   iii. Provide an opportunity for exercise or perform range of motion procedures for a minimum of five minutes per restrained limb and repositioning; and
   iv. Assess the need for toileting and assist with toileting or incontinence care.
3. Ensuring adequate fluid intake;

4. Ensuring adequate nutrition through meals at regular intervals, snacks, and assistance with feeding if needed;
5. Assistance with bathing as required at least daily; and
6. Ambulation at least once every two hours, if clinically feasible.

F. The facility should have written policies and procedures for interventions by nursing personnel for residents in restraints for overnight sleeping. These policies and procedures should include at least the following and should be implemented in accordance with nursing scope of practice, as set forth by the New Jersey Board of Nursing;

1. Visual observation based on resident's condition, occurring at least every one to two hours;
2. Administration of fluids as required;
3. Toileting as required;
4. Release of restraints at least once every two hours for repositioning and skin care, if clinically indicated; and
5. Prohibition of any method of restraint which places the resident at clinical risk for circulatory obstruction.