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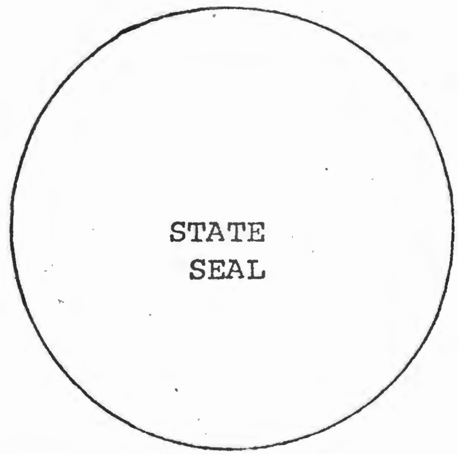
State of New Jersey
Department of Institutions and Agencies
Division of Medical Assistance and Health Services
Trenton



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MANUAL OF STANDARDS FOR AN INTERMEDIATE CARE FACILITY

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INTRODUCTION

(1) These standards were developed to comply with the intent and requirements of Title XIX of the Social Security Act, as amended, for the care, treatment, health, safety, welfare and comfort of residents in Intermediate Care Facilities.

(2) Intermediate Care Facilities to which these standards apply are medically and nursing oriented institutions or distinct parts of institutions as defined herein, licensed by the Department of Health licensing authority, and approved by the Department of Institutions and Agencies for provider participation in the Title XIX Medicaid Program.

(3) These standards supplement current licensing laws and licensing standards.

(4) All Intermediate Care Facilities certified as eligible for participation under Title XIX will maintain at least these standards on a continuing basis. In the event any of these standards are not maintained, the administrator will be given a reasonable time, not to exceed 30 days, to either correct the deficiencies in question or to submit a plan for correction of the deficiencies. Provider reimbursement will not be suspended during such period. Deficiencies affecting the health, welfare and safety of residents are to be corrected immediately if the home is to continue in a participating status.

(5) Representatives of the Department of Health and the Department of Institutions and Agencies shall have access, at all times, to the premises of the participating Intermediate Care Facility

and access to and private interviews with recipients of medical assistance. Such personnel, as representatives of these Departments, will be treated with courtesy as befits their professional status.

(6) It is not the intent of an Intermediate Care Facility to include individuals requiring care of a more complex nature, that is, skilled nursing techniques on a daily basis or medical therapy of intensive degree. The best interests of such individuals would be served in a skilled nursing facility or a hospital. It is also not the intent of this Program to include individuals requiring only room and board accommodations. Intermediate Care is a gradation of the medically oriented nursing care programs, and as such, requires supervision and care of the various elements of total health care by the health care team since the residents may not function independently. Supervision and care are necessary because of mental or physical impairment, or a combination of impairments, ranging from judgmental defects with concomitant disturbed behavior or inability to adhere to outlined medication schedules up to and including the type of case requiring nursing personnel services for daily management of simple medical treatment plans.

Not only should the Intermediate Care Facility meet the medical and basic social needs of the recipient, but should make available regularly, social and recreational activities involving active participation by the resident, entertainment and opportunities for participation in community activities as possible and appropriate.

100. DEFINITIONS

The following definitions are applicable for this Manual.

100.1 INTERMEDIATE CARE FACILITY

An Intermediate Care Facility is an institution or a distinct part of an institution licensed by the State Department of Health; constructed, equipped, maintained and operated in compliance with all applicable State and local laws affecting the health, welfare and safety of the residents and meets all the conditions of participation for the Medical Assistance Program as defined in these standards.

100.2 DISTINCT PART OF AN INSTITUTION

A "distinct part" of an institution is defined as a part which meets the definition of an Intermediate Care Facility with the following conditions:

(1) Identifiable Unit

The "distinct part" of the institution is an entire unit such as an entire ward or contiguous rooms, wing, floor, or building. It consists of all beds and related facilities in the unit and houses all residents, except as hereafter provided, for whom payment is being made for intermediate care. It is clearly identified and is approved, in writing, by the agency applying the definition of Intermediate Care Facility herein.

(a) Staff

Appropriate personnel are assigned as defined herein

and work regularly in the unit. Immediate supervision of staff is provided in the unit at all times by qualified personnel.

(b) Shared Facilities and Services

The distinct part may share such central services and facilities as management services, building maintenance and laundry, food, dining, recreation services, etc., with other units.

(c) Transfers Between Distinct Parts

In a facility having distinct parts devoted to skilled nursing home care and Intermediate Care, which facility has been determined by the Division to be organized and staffed to provide services according to individual needs throughout the institution, the foregoing paragraphs shall not be construed to require transfer of an individual within the institution when in the opinion of the individual's physician such transfer might be harmful to the physical or mental health of the individual.

100.3 MULTIPLE OCCUPANCY

Multiple occupancy in an institution is defined as the mixing of residents requiring various levels of care, i.e., skilled nursing home and intermediate, in either the entire facility or a distinct part of the facility.

(1) Applicable Standards

When residents are so admixed in the facility or unit, the basic standards applicable to the higher level of care shall be met except as follows:

(a) Nursing staff will be apportioned in the institution or unit based upon the census of skilled nursing and intermediate care residents at any given time. This shall be accomplished on a ratio basis.

(b) The standards for physician services, resident care and / physical medicine and rehabilitation services, utilization and medical review, and pharmaceutical services of this manual will be applicable to intermediate care residents when admixed with skilled nursing residents.

(2) Other Requirements

(a) Reimbursement in all instances where skilled nursing and intermediate care residents are admixed shall be on the basis of the level of care required as determined by the Division of Medical Assistance and Health Services.

100.4 PHYSICIAN

"Physician" means a doctor of medicine or osteopathy licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the State in which he practices.

100.5 RESIDENT

Resident is anyone accepted for care in the institution who meets the requirements for Intermediate Care level status as defined in Appendix A of this Chapter.

100.6 ACT

Social Security Act.

100.7 CFR

Code of Federal Regulations.

100.8 DIVISION

Division of Medical Assistance and Health Services.

100.9 DEPARTMENT

Department of Institutions and Agencies.

100.10 COMMISSIONER

Commissioner of Department of Institutions and Agencies.

100.11 DIRECTOR

Director of Division of Medical Assistance and Health Services.

100.12 ADMINISTRATOR

An Administrator is a person who is licensed in New Jersey under the provisions of Chapter 356, P.L. 1968.

100.13 SECRETARY

United States Secretary of Health, Education and Welfare.

100.14 PHYSICAL THERAPIST

A qualified physical therapist is one who:

(1) Has graduated from a physical therapy curriculum approved by -

(a) The American Physical Therapy Association; or

(b) The Council on Medical Education and Hospitals of the American Medical Association; or

(c) The Council on Medical Education of the American Medical Association in collaboration with the American Physical Therapy Association; or

(2) Prior to January 1, 1966 -

(a) Has been admitted to membership by the American Physical Therapy Association; or

(b) Has been admitted to registration by the American Registry of Physical Therapists; or

(c) Has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education, is licensed or registered as a physical therapist, and where appropriate, has passed a State examination for licensure as a physical therapist; or

(3) If he is currently licensed or registered to practice physical therapy pursuant to State law, he:

(a) Was licensed or registered prior to January 1, 1970 and has achieved a satisfactory grade through the examination conducted by or under the sponsorship of the Public Health Service; or

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

(4) If trained outside the United States -

(a) Has graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and

(b) Is a member of a member organization of the World Confederation for Physical Therapy; and

(c) Has completed one year's experience under the supervision of an active member of the American Physical Therapy Association; and

(d) Has successfully completed a qualifying examination as prescribed by the American Physical Therapy Association.

100.15 OCCUPATIONAL THERAPIST

A "qualified occupational therapist" is registered by the American Occupational Therapy Association or is a graduate of a program in occupational therapy approved by the Council of Medical Education of the American Medical Association and is engaged in obtaining the required supplemental clinical experience prerequisite to registration by the American Occupational Therapy Association.

100.16 SPEECH THERAPIST

A "speech therapist" is certified by the American Speech and Hearing Association, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

100.17 DIRECTOR OF NURSING SERVICES

In a separate intermediate care facility or in a multiple occupancy facility which includes intermediate care, the Director of the Nursing Service shall be a Registered Professional Nurse whose services shall be considered administrative and counted as direct resident care on the following basis:

(1) A facility up to 20 beds may credit 50% of the time.

(2) A facility from 20-29 beds may credit 33 1/3% of the time.

(3) A facility from 30-39 beds may credit 25% of the time.

100.18 NURSE SUPERVISOR

A nurse supervisor shall be a Registered Professional Nurse or a practical nurse licensed other than by waiver in New Jersey and qualified by experience and training to assume responsibility for nursing personnel and the nursing care in several nursing units, wings, or floors of a large facility as assigned.

100.19 HEAD NURSE

A head nurse shall be a Registered Professional Nurse or a practical nurse licensed other than by waiver in New Jersey who shall be qualified by experience and training to assume responsibility for nursing care and for the activities of staff nurses and nurses' aides in one or more adjacent resident areas.

100.20 CHARGE NURSE

For purposes of the Intermediate Care Facility Program, the term "Charge Nurse" shall be a generic term denoting the function of being "in charge." It shall mean the Director of Nursing Service and when she is absent it shall mean the nurse designated as her relief. This shall also mean an Assistant Director of Nursing Service, a Nurse Supervisor or a Head Nurse.

100.21 REGISTERED PROFESSIONAL NURSE

A Registered Professional Nurse is a nurse currently registered in the State of New Jersey to practice professional nursing.

100.22 STAFF NURSE

A staff nurse shall be a Registered Professional Nurse or a Licensed Practical Nurse who gives direct care to residents.

100.23 LICENSED PRACTICAL NURSE

A Licensed Practical Nurse as referred to herein shall be one of the following:

(1) A nurse who is a graduate of a State-approved school of practical nursing or the equivalent as determined by the New Jersey Board of Nursing and who is currently licensed as a practical nurse by the New Jersey Board of Nursing. (The license number is preceded by the letter "P").

(2) A nurse who is licensed by Endorsement of the New Jersey Board of Nursing. This category may include those coming from other states who may or may not be eligible to take the examination in New Jersey, including those licensed by waiver in other states. (The license number is preceded by a letter "E").

(3) A nurse who is licensed by waiver of examination in New Jersey and who does not qualify by training and education. (This license number is preceded by the letter "W").

100.24 NURSES' AIDE

The nurses' aide shall be a non-professional employee who has had a short formal course of nurses' aide training in a vocational school or hospital, or has received on-the-job training within the facility to assist in giving direct patient care to residents.

100.25 NON-NURSING PERSONNEL

Non-nursing personnel are all personnel not assigned to the Department of Nursing Service and, therefore, responsible for duties other than resident care.

APPENDIX A

CRITERIA FOR ADMISSION TO AND CONTINUING STAY IN AN INTERMEDIATE CARE FACILITY

A. DEFINITION OF RESIDENT

A resident in an Intermediate Care Facility is a person who requires supervision and care on a daily basis by licensed and trained personnel, and who has been certified by a licensed physician to be free from communicable disease and not in need of skilled nursing care on a continuing basis; most such residents will be ambulant or partially ambulant, with or without assistance (including mechanical and/or prostheses.) This shall not be construed to prevent medical and nursing care of residents on an intermittent basis, in emergencies or during temporary illness. The factors explaining the definition are as follows:

1. A resident in an Intermediate Care Facility shall be a person who -

   (a) for reasons of health and/or psycho-social conditions and/or disabilities requires bed and board, supervision, care, minimal treatment, and/or restorative services designed to encourage self-care and independence (preventive care shall be an important factor) in an institutional setting, or

   (b) whose health and psycho-social needs cannot be met satisfactorily in a sheltered boarding home, boarding home, his own or substitute home through the utilization of ambulatory services such as home health, physician's office, outpatient hospital or independent clinic, health center or health maintenance organization, or

   (c) does not need continuous 24-hour medical, nursing, rehabilitative and/or other specialized care in an acute general, mental, specialized, or tuberculosis hospital and who does not need skilled nursing or rehabilitative services on a daily basis which can only be provided in a skilled nursing facility.

2. The resident has a recognizable physical and/or mental condition of such a degree to require -

A. Continuing medical services and supervision in which

(a) disease symptoms are relatively and generally mild (i.e., compensated cardiopulmonary states; CVA with high functional level; stable renal problems; controlled diabetes with mild complications, etc.) and/or

(b) the resident is recuperative or convalescent (i.e., postoperative states where the resident does not require skilled nursing care, but cannot receive essential services at home), or

(c) certain cases and stages of chronic diseases not requiring skilled nursing care.

B. Supervised living accommodations with need for minimal treatment, observation and/or instruction for those individuals who are unable to adequately function independently because of impairments ranging

(a) from mild judgmental defect (i.e., inability to adhere to defined medication schedules without supervision; occasional instruction in the use of prostheses, etc.)

(b) to those cases requiring considerable personal and social care (i.e., grooming, securing routine medical care, maintaining continuing relationship with family and friends, aiding to adjust to institutional life etc.)

C. A combined plan for medical, personal and social rehabilitation with a need for only slightly controlled activities (i.e., self-ambulation, well controlled use of mechanical aids to movement with occasional adjustment; nearly fully returned to pre-illness physical capabilities, etc.).

D. Services which could best be made available through institutional facilities with little deviation from acceptable behavior patterns (i.e., provision of or access to meaningful activities; development of social relationship; assistance to participate in community activities; assistance to secure health or other services as required, etc.)

E. Services of a nature to eliminate the need for skilled nursing techniques or complex medical therapy (i.e., requirement for skilled nursing home care or hospitalization absent.)

F. Care on a daily basis of such a nature as to necessitate services in accordance with the orders of the attending physician. This includes an organized program of basic care with periodic observation and assessment of the resident's needs by licensed nurses.

G. A continuing need for the provision of the following services as indicated:

(a) Proper positioning of residents in bed, wheelchair or other accommodation to prevent deformity and decubitus ulcers.

(b) Observation of vital signs and recording of findings in the resident's medical record.

(c) Bed, shower or tub baths requiring assistance.

(d) Treatment of skin irritation, small superficial lesions, stage 1 and 2 decubitus ulcers.

(e) Routine changing of dressings in chronic, noninfected skin conditions.

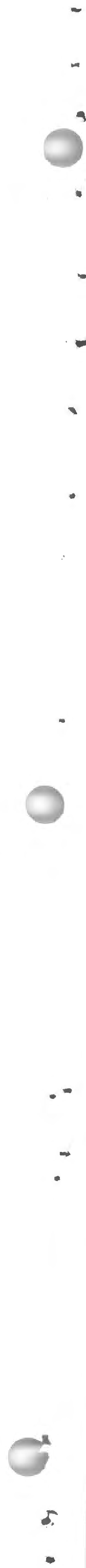
(f) Training and assistance in resident transfer techniques (bed to wheelchair, wheelchair to commode, etc.)

(g) Normal range of motion exercises as part of routine maintenance care.

(h) Care of residents with casts, braces, splints, or other appliances and self help devices.

(i) Use of protective restraints, bed rails, binders and supports if ordered by a physician and are provided in accordance with written resident care policies and procedures.

(j) Use of intermittent positive pressure breathing equipment and nebulizers.



(h) Administration of oxygen on [illegible] or short term basis.

(i) Training and assistance in activities of daily living such as dressing, bathing, eating, personal hygiene, communication and exercise.

(j) Administration of behavior modification or reality orientation techniques.

(k) Activity programming to encourage self-care, maintenance of normal activity through exercise, intellectual and sensory stimulation and social interaction.

(l) Assisting in the restoration and maintenance of bowel and bladder continency.

3. A regular and continuing need for provision of the following services -

(a) Administration of topical, oral and selected injectable medications.

(b) Prevention of skin irritation and decubitus ulcers including routine prophylactic and palliative skin care, i.e., bathing, application of creams and lotions.

(c) Maintenance care of uncomplicated and regulated colostomy.

4. Administration of Medications

A unit dose system may be used in all intermediate care facilities for proper control.

200. ELIGIBILITY FOR PARTICIPATION

(1) An Intermediate Care Facility may be certified for participation provided that:

(a) it is licensed as an Intermediate Care Facility by the Department of Health; and

(b) the Department of Health has certified to the Department of Institutions and Agencies that the institution meets the standards for an Intermediate Care Facility as defined herein for Title 19 Medicaid participation.

(2) A multiple occupancy facility for skilled care and intermediate care may be certified for participation provided that:

(a) it is licensed as a nursing home by the Department of Health; and

(b) the Department of Health has certified to the Department of Institutions and Agencies that the institution or the distinct participating part(s) meet the standards for a skilled nursing facility and the standards for an Intermediate Care Facility as defined herein for Title 19 Medicaid participation.

(3) A written request for participation made by the owner and/or his authorized representatives has been approved by the Department of Institutions and Agencies in accordance with the provisions of this chapter.

201. REQUIREMENTS FOR PARTICIPATION

The owner and/or his authorized representatives must enter into a written provider agreement with the Department of Institutions and Agencies concerning participating status. The Department of Institutions and Agencies reserves the right to reject any request for participation or to terminate a participating status, for resident neglect, abuse, conditions affecting health, welfare and safety, charges above the allowable rate, or any other practices deemed to be not in the best interest of the resident or the Medical Assistance Program.

202. PRIOR TO INITIAL AGREEMENT

Prior to entering into an agreement with a facility for the provision of Intermediate Care Facility services under Title XIX, the State Department of Health, following an appropriate survey and evaluation, must submit a report to the Division which indicates that the facility meets all applicable Federal, State and local requirements for participation in the program. The determining authority for meeting such standards shall rest with the Division.

203. AGREEMENT REQUIRED

Each facility before receiving payments under Title XIX must enter into an agreement with the Division. The agreement shall be for a period of twelve months if the facility does not have deficiencies and for a period of

six months or less if the facility has deficiencies. The agreement requires the facility to comply in full with the rules and regulations contained in this manual and to furnish the Division and the Department of Health with information and documentation as may be required or requested as necessary to disclose the extent of the services provided to individuals receiving assistance under the Medicaid program.

204. AGREEMENTS WITH INTERMEDIATE CARE FACILITY [illegible] IN SUBSTANTIAL COMPLIANCE

Under specified circumstances, the Division of Medical Assistance and Health Services may enter into an agreement for a limited period of time with a facility that qualifies as an Intermediate Care Facility [illegible] and has been determined or certified to be in substantial compliance with requirements. In such cases, the Division may enter into an agreement for the provision of services and making of payments for a period not to exceed six months, provided that:

(1) The Division finds, on the basis of documented evidence derived from a survey, that:

(a) there is a reasonable prospect that the deficiencies can be corrected within six months.

(b) The Intermediate Care Facility [illegible] provides, in writing, a plan acceptable to the Division for such

corrections with a target date for such correction;

(c) the deficiencies, individually or in combination, do not jeopardize the health, welfare and safety of the residents.

(2) The Division

maintains on file a written justification of its finding that the deficiencies, individually or in combination, do not jeopardize the health, welfare and safety of the residents.

(3) No more than two successive six-month agreements shall be executed with any Intermediate Care Facility ~~[illegible]~~ having deficiencies and no second agreement shall be executed if any of the deficiencies existing are the same as those which occasioned the prior agreement, unless the Division finds, on the basis of documented evidence derived from a survey of the facility, that the facility has made substantial effort and progress in correcting such deficiencies.

205. WAIVER OF REQUIREMENTS

Under specified circumstances, the Division may waive certain requirements (e.g. sanitation, physical environment, fire and safety and hospital agreements) applicable to an Intermediate Care Facility ~~[illegible]~~ if:

(1) It finds, on the basis of documented evidence derived from a survey, that:

in unreasonable hardship upon the Intermediate Care Facility; and

(b) the waiver of the specific provision(s) does not adversely affect the health, welfare and safety of the residents in the facility and a written justification of such a finding is maintained on file; and

(c) where structural changes in the facility are necessary to meet a provision, the change is of such magnitude as to be infeasible or economically impracticable; delay in making such changes would not adversely affect the health, welfare and safety of residents; and an explanation of this finding is maintained on file.

(2) It has assurance that the conditions of waiver are re-determined at the time of each survey and written evidence of such redetermination is maintained on file.

(3) The waiver of requirements is rescinded at any time any of the conditions are found no longer to apply.

NOTE: Only the specified requirements listed in Section 205 may be waived.

Items not so designated may not be waived. A requirement that is waived differs from certification of a facility with deficiencies, both in the procedures to be followed and the requirements involved.

206. ASSURANCE OF COMPLIANCE PRIOR TO RENEWAL OF AGREEMENT

The execution of a new agreement shall be contingent upon a determination of continued compliance with the conditions for qualification as an Intermediate Care Facility [illegible] and

for receipt of payment for Intermediate Care Facility services. There shall be at least an annual on-site inspection of the facility by qualified personnel at least once during the term of an agreement or more frequently if there is a question of compliance with the requirements. The Division shall review the information thus obtained.

207. DURATION OF AGREEMENT

The term of an agreement may not exceed one year. In the case of any facility certified to be in compliance except for correctable deficiencies, the term of an agreement may not exceed six months, but may be for a lesser period.

208. MAINTENANCE OF INSPECTION REPORTS

All information and reports used in determining whether an Intermediate Care Facility meets the requirements of this manual shall be maintained on file for a period of at least three years by the facility. This shall include:

(1) Copies of reports of inspections made with notations indicating whether each requirement for which the inspection is made is or is not satisfied, with documentation of deficiencies.

(2) Copies of official notices of waiver of any requirement.

209. AGREEMENT TO ACCEPT MEDICAID PATIENT-RESIDENTS

Any facility approved to participate for payment as an Intermediate Care Facility under the Title XIX Medicaid Program shall, as a condition for approval, agree to accept Medicaid residents on a continuing and on-going basis in keeping with the following provisions:

(1) The Intermediate Care Facility shall maintain Medicaid residents only in the section(s) certified and approved by the Medicaid Program. Such section(s) shall be clearly identified by unit(s) and bed capacity. Such section(s) shall be clearly identified by unit(s) and bed capacity whether a free-standing Intermediate Care Facility, a distinct part of a skilled nursing or other type facility, or as a multiple occupancy provider for various levels of patient care.

(2) The Intermediate Care Facility ~~(Medicaid)~~ shall not refuse to accept Medicaid residents when empty beds in the certified section(s) are available and the number of Medicaid residents in the facility is below the number stipulated in the provider agreement.

(3) In no instance shall the Intermediate Care Facility ~~(Medicaid)~~ initiate or request the removal of a resident admitted as a Medicaid recipient for the sole purpose of making an additional bed(s) available for a private paying or other non-Medicaid resident.

(4) Failure to comply with this agreement, in whole or in part, shall be considered sufficient cause for the Division to discontinue its approval of and reimbursement to the facility as an Intermediate Care Facility ~~(Medicaid)~~ under the Title XIX Medicaid Program.

210. SUSPENSION OR REVOCATION OF PROVIDER AGREEMENTS

Participation in the New Jersey Medical Assistance Program by a provider of services is subject to suspension or revocation in order to protect the health of the recipients and the funds appropriated to carry out the provisions of N.J.S.A. 30:4D-1 et seq.

(1) The Director may revoke or suspend the status of a provider of services under the Medical Assistance Program for violation of the provisions of P.L. 1968, c. 413, or any rule or regulation promulgated by the Commissioner pursuant thereto.

(2) The Director may suspend any provider of services prior to any hearing when, in his opinion, such action is necessary to protect the public welfare and the interests of the Medical Assistance Program.

(3) The suspension or revocation by the Director of any provider of service shall preclude such provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation or other association to the Medical Assistance Program for any services or supplies he has provided under such program, except for services or supplies provided prior to the suspension or revocation. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the Medical Assistance Program for any services or supplies provided by a person within such organization whose status has been suspended or revoked by the Director, except for services or supplies provided prior to the suspension or revocation.

(4) Where the provisions of this chapter or the regulations promulgated by the Commissioner, through the Division of Medical Assistance and Health Services, are violated by a provider of service which is a clinic, group, corporation, or other association, the Director may suspend or revoke such organization and any individual person within said organization who is responsible for such violation.

(5) A person whose status as "provider" of service under the Medical Assistance Program has been revoked may petition the agency for reinstatement after a period of not less than one year has elapsed from the effective date of the decision or from the date of the denial of a similar petition.

(6) The Director may revoke the status of any provider of service found guilty of violating the penalty provision, or any part thereof, set forth in P.L. 1968, c. 413, or found guilty of

any crime or quasi-crime perpetrated against the Division of Medical Assistance and Health Services.

210.1 IMPLEMENTATION BY DIVISION

The Division will implement these policies in the following manner for an Intermediate Care Facility:

(1) All Intermediate Care Facility survey and evaluation reports will be sent to the Division and be routed through the office of Medical Care Administration for review by the Chief of Medical Care Administration, Chief of the Bureau of Long Term Care and Chief of the Bureau of Utilization Review. A comment and control sheet shall be used for this purpose.

(2) If it is the concurrent opinion of the above-mentioned Chiefs that the facility is not being maintained and/or operated in keeping with Intermediate Care Facility standards and requirements and should no longer be utilized for the placement and payment of Intermediate Care Facility -residents, the Chief of Medical Care Administration will recommend to the Director of the Division that steps be initiated to terminate the facility's provider agreement.

(3) If the recommendation is approved by the Director of the Division, the facility will be notified in writing of the Division's intent to terminate the facility's provider agreement in keeping with the fair hearing procedure adopted by the Division in accordance with the New Jersey Administrative Procedure Act.

(4) Upon receipt of notification to a provider of the intent to terminate the facility's provider agreement, the provider may submit a request to the Director, in writing, and within 20 days of the receipt of said notification, for a fair hearing.

ADMISSION, TRANSFER AND DISCHARGE POLICIES

300. ADMISSION POLICIES

300.1 GENERAL REQUIREMENTS

A. The individual or officers responsible for the institution shall develop written procedures to govern admissions, general care policies and discharges. These written procedures must be formulated with the advice of one or more physicians and one or more Registered Professional Nurse (s) and/or Licensed Practical Nurse (s) and shall be available at the facility for review by authorized State personnel.

B. All residents admitted to an intermediate care facility (~~ICF~~) shall be admitted only if they require this level of care and only on orders of a licensed physician who will provide or make provision for the adequate medical care of the resident.

300.2 RESIDENT MEDICAL/SOCIAL INFORMATION

The facility shall be responsible for obtaining, prior to or at the time of admission, resident information including current medical findings, diagnoses, rehabilitation potential, medical and social plans including considerations of alternate care, and orders from a licensed physician for the continuing care of the resident. If the referring physician is not the physician chosen to be the treating physician, it will be necessary for the resident to be seen by the treating or attending physician within 48 hours after admission.

300.3 INFORMATION FURNISHED TO RESIDENT BY THE FACILITY PRIOR TO ADMISSION

Prior to admission the administrator or his authorized representative shall acquaint the prospective resident and/or his sponsors with the institution and its services, and thereby provide a basis for individual adjustment to any change in living arrangements. The administrator shall inform the prospective resident and/or his sponsors of the type of care the institution is classified and equipped to provide and to advise that a change in the resident's condition could necessitate the need for a transfer to another unit or facility.

The administrator or his authorized representative shall fully acquaint the resident with the staff, other residents, rights, privileges and obligations assumed by residents.

300.4 INFORMATION FURNISHED TO PERSON(S) LEGALLY RESPONSIBLE FOR RESIDENT

The resident and/or guardian, person or agency placing a resident in the institution shall be furnished a written copy of the admission and general operating policies of the intermediate care facility at the time the resident is admitted. The policies shall include, but not be limited to, responsibility for medical care and medication, type of care, charges for services and refund policies.

300.5 RESIDENT PREFERENCE

Insofar as possible and when not detrimental to the administration of the facility, each resident should have his wishes respected concerning with whom a room is shared. When a resident is moved within the home, the resident, his sponsor and/or guardian and attending physician should be advised of the necessity or reason for the move. The intent of the foregoing is to preserve for the resident maximum right of self-determination, insofar as space consideration will permit, in matters relating to his personal comfort and happiness. This principle recognizes that residents are happiest and most likely to respond to therapy when in congenial surroundings.

300.6 OBSERVANCE OF RELIGIOUS BELIEFS

The administration of the facility shall not promulgate any policy which shall abrogate the religious beliefs and rights of the resident. However, the administration may take appropriate measures to discover and prevent the spread of infection or contagious disease for the purpose of protecting the environmental health at the facility.

301. TRANSFER POLICIES

301.1 Transfer Agreement

(1) Each intermediate care facility ([illegible]) must have a written agreement (s) with one or more general hospitals within reasonable proximity to the facility, under which such hospital or hospitals will provide needed diagnostic and other services to residents of the intermediate care facility ([illegible]) and under which the hospital or hospitals agree to timely acceptance, as residents thereof, of acutely ill residents of the intermediate care facility ([illegible]) who are in need of hospital care. A copy of this written agreement (s) and any subsequent changes thereto, shall be on file with the Division.

(2) The arrangements with a hospital (s) must include written agreements providing a basis for effective working relationship under which in-patient hospital care shall be available promptly to the intermediate care facility ([illegible]) resident, when needed, and which include, as a minimum:

(a) procedures for transfer of acutely ill residents to the hospital ensuring timely admission;

(b) provisions for continuity in the care of the resident and for the transfer of pertinent medical and other information between the intermediate care facility ([illegible]) and the hospital, which shall include, as a minimum, current medical findings; medications;

diagnosis; summary of course of treatment; rehabilitation potential and the applicable nursing, dietary and restorative aspects of care;

(c) provisions for the prompt availability of diagnostic and other medical services;

(d) establishment of responsibility for the prompt exchange of resident information to enable each institution to determine its ability to provide the required care and services to the resident;

(e) provision for the transfer of any or all personal effects and pertinent information relating to such items.

(3) Each intermediate care facility must have a written agreement(s) with one or more skilled nursing care facilities to provide for timely acceptance of residents whose status has changed and are in need of skilled nursing facility care.

301.2 IN-HOUSE TRANSFER

The requirement for room assignments and transfers of residents within the intermediate care facility is covered under Chapter 1600 on Civil Rights.

301.3 RESPONSIBILITY FOR RESIDENT TRANSFERS

A. The Division shall have the sole responsibility and authority, as defined under prior authorization procedures, of initiating and approving the transfer of a Medicaid recipient for reimbursement purposes from or to any level of care which is directly under the jurisdiction of the Medicaid program. This shall include skilled nursing home care and intermediate care.

B. When a Medicaid recipient's condition changes and indicates the need for transfer from a higher to a lower level of care (skilled nursing to intermediate care), upon notification of such a change from the skilled nursing home, the Division will approve the lower level of care for placement and reimbursement purposes without prior authorization. However, continued placement and reimbursement at the lower level beyond the 30 days will require Division authorization. In all such instances, the Division shall be immediately notified by the skilled nursing facility of the effective date of such a change in the patient's level of care.

Note: There shall not be any automatic 30-day approval in those instances where a resident's condition requires a change from a lower level to a higher level of care (intermediate care to skilled nursing.)

302. DISCHARGE POLICIES

302.1 Discharge to Resident's Home

It shall be incumbent upon the intermediate care facility (~~medical~~) from which the resident is discharged, to have available all pertinent and relevant information necessary for continuing care of the resident and to make such information available to the physician who assumes responsibility for such continuing care.

302.2 Resident Discharge and/or Transfer Requirement

It is required that no resident in an intermediate care facility (~~medical~~) shall be discharged or transferred from the facility except on written order from the attending physician or a physician acting for the attending physician, with prior notification of the next of kin or sponsor. An exception would be when a mentally competent resident signs himself out of the facility.

ADMINISTRATION AND ORGANIZATION

400. GOVERNING BODY

There shall be a governing body which shall assume full legal responsibility for the overall operation of the Intermediate Care Facility ([illegible]). The governing body shall be held responsible for compliance with all applicable laws, regulations and standards. If an organized body is not available, the individual owner(s) or partners of the facility shall be held legally responsible for the conduct of the facility and compliance with applicable laws, regulations and standards.

401. OWNERSHIP

(1) Facilities that are in compliance with the requirements applicable to Intermediate Care Facilities [illegible] may participate in the Program and receive payments under Title XIX regardless of their ownership category, i.e. proprietary, voluntary non-profit, or Government. Each facility, however, shall supply to the State licensing agency, the Division of Health Facilities, Department of Health, full and complete information as to the identity:

(a) of each person having (directly or indirectly) an ownership interest of 10 percent or more in such Intermediate Care Facility ([illegible]);

(b) of each officer and director of the corporation if the Intermediate Care Facility ([illegible]) is organized as a corporation;

(c) of each partner if the Intermediate Care Facility [illegible] is organized as a partnership.

(2) Each facility shall promptly report to the Division within 48 hours any changes on ownership which would affect the current accuracy of the information required.

402. ORGANIZATION AS A DISTINCT PART

An Intermediate Care Facility participating in and receiving payments under the Title XIX program may be a free-standing, separate institution, qualifying and serving in its entirety as an Intermediate Care Facility or it may be a distinct part of a larger institution. If the facility is operated as a distinct part of a larger institution (a unit attached to a general hospital, the nursing unit of a home for the aged or one unit of some other institution), the distinct part serving as the Intermediate Care Facility shall meet the following conditions:

(1) Is a distinct identifiable unit;

(2) Is licensed or formally approved as an Intermediate Care Facility by the State licensing agency;

(3) Meets all requirements applicable to Intermediate Care Facilities and payments for Intermediate Care services under Title XIX.

403. ORGANIZATION UNDER MULTIPLE OCCUPANCY

An Intermediate Care Facility participating in and receiving payment under the Title XIX Medicaid program may be organized and operated under the multiple occupancy provisions with different levels of patient care in the institution or identifiable units as defined elsewhere in this manual. The multiple occupancy facility or sections shall meet the following conditions:

(1) Is an identifiable facility or unit for multiple occupancy.

(2) Is licensed or formally approved for multiple occupancy by the State licensing agency.

(3) Meets all requirements applicable to intermediate care under multiple occupancy provisions for payment purposes under Title XIX.

404. ADMINISTRATOR

Every facility providing intermediate care services under the provisions of this manual, (skilled nursing and intermediate levels of care), whether a free-standing structure or a part of a
whether under multiple occupancy or a distinct part
structure, shall be operated under the supervision of an Administrator who is licensed in accordance with Chapter 356, P.L. 1968, or as amended and promulgated by the State Department of Health.

The facility shall employ staff sufficient in number and in qualifications to meet the needs of the residents whom it accepts for care. Specific staff requirements for different services are described in various Chapters of this Manual.

405.1 PERSONNEL HEALTH PROGRAM

(1) All regular paid personnel are required to have a pre-employment physical examination including a chest x-ray or Tine test, serology and stool examinations if a history of typhoid fever and/or parasites is elicited.

(2) A physical examination, including chest x-ray or Tine test, shall be repeated annually on all regular paid personnel.

(3) Personnel who show signs of respiratory infections, skin lesions, diarrhea, venereal disease and other communicable diseases shall be excluded from work to return only after approval by a physician.

(4) Personnel absent from duty because of any reportable communicable disease, infection or exposure thereto, shall be excluded from the facility until examined by a licensed physician and certified by him to the Administrator as not suffering from any condition that may endanger the health of the residents or employees. For this purpose, the sections on "Reportable Diseases" and "Regulations Concerning Isolation of Persons Ill or Infected with a Communicable Disease and Restrictions of Contacts with Such Communicable Disease", of the State Sanitary Code, New Jersey State Department of Health, January 1, 1966 or as amended shall be used as a reference.

406. MEDICAL AND NURSING CARE POLICIES

There shall be written policies to govern the nursing care and related medical and other services provided in the facility, in accordance with the requirements of various Chapters in this Manual, which shall reflect awareness of and provisions for meeting the total needs of the resident.

407. FISCAL RESPONSIBILITY

Any facility certified as an Intermediate Care Facility which handles resident funds shall establish and maintain appropriate and accurate records and accounts of all receipts and disbursements of resident funds, which shall be subject to review and fiscal audit by the State as may be required to maintain the integrity of the Title XIX Program.

408. STAFF DEVELOPMENT

(1) An in-service on-going educational program for all personnel shall be developed.

(2) Regularly planned staff meetings shall be conducted by the Administrator and the Director of Nursing Services, with the participation of nursing and other staff.

CHAPTER 500

PHYSICIAN SERVICES

500. GENERAL REQUIREMENTS

(1) All residents admitted to an intermediate care facility ~~(medical)~~ shall be admitted only on orders of a licensed physician who will provide or make provision for the adequate care of the resident.

(2) Each resident's care shall be continuously under the supervision of an attending physician or, in the absence of an attending physician, a physician who accepts responsibility for the adequate care of the resident and so recorded in each resident's clinical record.

(3) The institution shall have a licensed physician or physicians who will be available to furnish necessary medical care in case of an emergency if the physician responsible for the care of a resident is not immediately available. There shall be established procedures to be followed in an emergency which covers the immediate care of the resident, persons to be notified and reports to be prepared.

501. PHYSICIANS' SERVICES

Physicians' Services are "those services provided within the scope of practice of his profession as defined by State law, by or under the direct personal supervision of an individual licensed under State law to practice medicine or osteopathy". "Under the direct personal supervision of" is the actual physical presence of the physician in the immediate area where a given service is rendered in order to oversee its accurate implementation where such service is considered to be within the scope of his practice.

502. MEDICAL FINDINGS & PHYSICIAN'S ORDERS (ADMISSION PERIOD)

Prior to or at the time of admission, the facility shall be responsible for obtaining resident information which includes current medical findings, diagnoses, rehabilitation potential, a summary of the course of treatment followed in the hospital, and orders from a physician for the immediate care of the resident.

(1) If the above information is not available in writing in the facility upon admission of the resident, it shall be obtained by the facility within 48 hours after admission.

(2) If medical orders for the immediate care of a resident are unobtainable at the time of admission, the physician with responsibility for emergency care shall give temporary orders.

(3) A current hospital discharge summary containing the above information is acceptable. If the admission is from other than a hospital, orders from a physician shall be obtained for the resident immediately after admission.

503. PHYSICIAN RESPONSIBILITY FOR CONTINUING CARE

Based on an evaluation of the resident's immediate and long term needs, the attending physician shall prescribe a planned regimen of medical care under the following headings:

1. Indicated medications
2. Restorative services
3. Diet
4. Special procedures
5. Activities
6. Plans for continuing care
7. Discharge

(1) The medical evaluation of the resident shall be based on a history and physical examination done within 48 hours of admission unless such examination was performed within 14 days prior to admission.

(2) The Director of Nursing and other appropriate personnel involved in the care of the resident shall assist in planning the total program of care.

(3) Orders concerning medications and treatments shall be in effect for the specified number of days indicated by the physician but in no case exceeds a period of 30 days. Vague and blanket orders are not acceptable. It shall be further incumbent upon the physician to review all orders and re-confirm in writing (i.e. "Orders reviewed and continued").

(4) Telephone orders are to be accepted only when necessary and only by licensed nurses. Telephone orders are to be written into the appropriate clinical record by the nurse receiving them and counter-signed by the physician at his next visit.

EMERGENCIES: In the event of an emergency telephone order where the life of the resident may be endangered or his clinical status may be compromised, such order must be countersigned by the physician within 12 hours from the time the order was given.

(5) Residents shall be visited by a physician at least once every 30 days. There shall be evidence in the clinical record of the physician's visits to the resident at each visit which shall include pertinent facts concerning the resident's current status, relevant findings and significant changes.

(6) Upon discharge, there shall be available for each resident, a summary which shall include diagnoses, medication, disposition of resident, plan of treatment, resident's condition and recommendations for future care.

504. PHYSICIAN OBLIGATION

In the event that conditions set forth in these standards are willfully violated by a physician responsible for the care of a resident, such violations shall be reported to the Division of Medical Assistance and Health Services in writing. The facility, at its discretion, may restrict the privileges of the physician and/or the Division of Medical Assistance and Health Services, following appropriate review and with just cause, may suspend the physician as an eligible Medicaid provider.

In the event of an accident or illness requiring care beyond the capabilities of the facility, the resident shall be transferred on orders of the attending physician to a facility where required services are available. The personnel of the Intermediate Care Facility shall have the authority, within their capabilities, to execute emergency procedures as prescribed by the attending physician.

All necessary records must be kept on emergency illnesses which do not necessitate patient transfer from the Intermediate Care Facility.

CHAPTER 600

RESIDENT CARE AND PHYSICAL MEDICINE AND REHABILITATION SERVICES

600. RESIDENT CARE AND PHYSICAL MEDICINE AND REHABILITATION SERVICES

601. RESIDENT CARE POLICIES

Written resident care policies shall be formulated with the advice of one or more licensed physicians and one or more registered professional and/or licensed practical nurses. The policies shall contain plans for assuring constructive care directed toward preventing, restoring and maintaining each resident at his best possible functional level, including continuing supervision by a physician who sees the resident as needed and, in no case, less often than quarterly. Activities designed to encourage self-care and independence, where possible, will be a part of the resident's treatment program. Preventive care should be stressed. These policies are to be reviewed at least annually.

(7) Care of residents in an emergency, during a communicable disease episode and when critically ill or mentally disturbed

(8) A written, rehearsed disaster plan (See Chapter 1300).

(9) Regular and emergency dental services

(10) Social and recreational activities

(11) Patient activities

(12) Clinical records

602. PHYSICAL MEDICINE AND REHABILITATION SERVICES

If physical medicine and rehabilitation services are made available, either on-site or off-site, as an integral part of a comprehensive medical care program, such services will include not only the administration of the prescribed therapy by qualified personnel, but also instructions to responsible members of the family in follow-up procedures necessary for the care of the patient upon discharge from the facility.

602.1 REQUIREMENTS FOR PHYSICAL MEDICINE AND REHABILITATION SERVICES

Previous physical medicine and rehabilitation services will be noted on the resident's clinical record as to the scope and extent of the services previously provided, length of time given and results obtained.

(1) The physician, in communication with the physical therapist, must prescribe (authorize in writing) the specific means and methods to be used by the therapist and the frequency of therapy services.

(2) Physical therapy must be related to the active treatment regimen designed by the physician to elevate the resident to his maximum level of function which has been lost or reduced by reason of injury, illness or disability.

(3) "Physical therapy as needed" or a similarly worded blanket prescription does not suffice as an accepted order since no specific treatment is named and the physical therapist is in effect prescribing the resident's regimen.

(4) The modalities, diagnostic tests, procedures and activities recommended by the therapists as necessary or appropriate to the resident's therapeutic regimen and the frequency of prescribed treatments must be approved by the physician prior to implementation.

(5) Written reports of evaluative and diagnostic tests performed and the specific treatments administered to residents shall be retained in the resident's clinical records. Progress notes shall be kept current by the physical therapist, countersigned by the physician.

(6) The qualified therapists providing therapeutic services to the residents shall cooperate with the medical and nursing staff in developing a total and continued plan of care for the residents.

(7) The therapists shall participate in the on-going educational program established for the nursing and ancillary personnel in the facility.

602.2 PROCEDURES WHEN PRESCRIBING PHYSICAL MEDICINE AND REHABILITATION SERVICES

(1) The physician shall place detailed orders on the resident's chart ("Physical therapy three times weekly" is not acceptable) prior to the treatment being initiated, specifying goals or potentials and the need for therapy.

(2) The physician shall instruct the physical therapist, or others of the allied health professions, to file notes in the resident's chart similar to nursing notes at least weekly, reflecting the resident's response to treatment.

(3) The physician shall review the resident's record at least quarterly to determine if treatment is being provided according to his orders and indicate by signing the treatment records. Treatment that is being provided but which has not been prescribed or authorized by the physician shall be discontinued immediately.

603. DISTINCTION BETWEEN PHYSICAL/ MEDICINE AND REHABILITATION SERVICES AND RESTORATIVE NURSING CARE

Restorative nursing procedures performed by licensed nurses, if approved by the physician, supplements and complements the other professional therapies

and services and are part of intermediate care facility (~~[illegible]~~) care when they are related to the total plan of rehabilitative care.

(1) Restorative nursing care includes such measures as maintaining good body alignment both in and out of bed; proper positioning of residents; active and passive range of motion exercises; keeping residents active and out of bed unless contraindicated by physician's orders; developing the resident's independence in the activities of daily living by teaching self-care; transfer and ambulation activities; promoting safety through maximum preventive measures regarding accidents; injuries or spread of infection, and correlating nursing with physical, occupational, speech and other therapies.

(2) Nursing personnel assist residents in practicing the use of prosthetic and orthotic devices during the functional activity in the resident care area to prepare them for independence in the activity, e.g. use of adaptive eating devices at meal time.

(3) The licensed nurse assists in the evaluation and appraisal of the resident's physical status and abilities in functional activity and, as part of the professional team, assists in the development of the resident's rehabilitation program, periodic reassessment and plans for discharge.

CHAPTER [illegible]

UTILIZATION AND MEDICAL REVIEW

[illegible]. MEDICAL AND UTILIZATION REVIEW

The Division of Medical Assistance and Health Services will conduct and monitor a medical and utilization review program which will include the following items:

(1) Medical evaluation of each resident's need for Intermediate Care Facility [illegible] care.

(2) A written plan of care and, where applicable, a plan of rehabilitation prior to admission to an Intermediate Care Facility [illegible].

(3) Periodic assessments and evaluation of all Intermediate Care Facilities [illegible] by one or more medical review teams composed of physicians and other appropriate health personnel.

MEDICAL AND CLINICAL RECORDS

800. MEDICAL RECORDS

801. GENERAL REQUIREMENT

An individual record must be maintained for each resident covering his medical, nursing, and related care in accordance with accepted professional standards.

802. MAINTENANCE OF CLINICAL RECORDS

The Intermediate Care Facility [illegible] shall maintain a separate clinical record for each resident admitted with all entries kept current, dated, and signed by appropriate personnel. The record includes:

(1) Identification and summary sheet(s) including resident's name, Social Security Number, Health Services Program Number, Person Number, marital status, age, sex, home address, and religion; names, addresses and telephone numbers of referral agency (including hospital from which admitted), personal physician, dentist, and next of kin or other responsible person; admitting diagnosis; final diagnosis; condition on discharge, and disposition and discharge summary.

(2) Initial medical evaluation including medical history, physical examination, diagnosis, and estimation of restoration potential.

(3) Authentication of hospital diagnoses, if applicable, in the form of a hospital summary discharge sheet, or transcript, or a report from the physician who attended the resident in the hospital, or a transfer form used under a transfer agreement.

(4) Signed physician's orders, including all medications, treatments, diet, restorative and special medical procedures required for the safety and well-being of the resident.

(5) Signed physician's progress notes including significant changes in the resident's condition, written at the time of each visit.

(6) Signed nurse's notes containing observations made by the nursing personnel including appropriate records of medication and treatment given; untoward reactions, if any, and observations of the resident's current condition. In addition, a monthly summary of condition shall be entered into each resident's record.

Incident Reports:

If an incident has occurred including errors in the administration of medication, involving a resident, a reference shall be made in the nursing notes with the completed incident report appended to the resident's record with a duplicate on file with the Administrator. The report shall include the date, time, extent of the incident, circumstances under which it occurred; witnesses, if any; action taken and any other relevant information. All information shall be signed by the reporting nurse and counter-signed by the attending physician.

(7) Signed medication and treatment record including all medications, treatments, and special procedures performed for the safety and well-being of the resident.

(8) Signed laboratory and x-ray reports.

(9) Consultation reports.

(10) Reports of any professional services.

(11) Therapy records.

(12) All entries on the resident's clinical record shall be current, dated and signed by the physician, nurse or therapist, where applicable.

803. DECEASED RESIDENT RECORD

The clinical record of a deceased resident shall be fully completed promptly. It shall include, in addition to the requirements in Section 802, the following:

(1) Written records made by the physician during the critical stages of illness.

(2) Written documentation of death pronouncement by the physician and the completion of the death certificate.

(3) Complete nurse's notes containing all necessary and pertinent information documenting the resident's progress during the illness and apparent demise, notification of physician and next of kin.

(4) Written record of the disposition of the remains in the nurses' notes.

804. RETENTION OF RECORDS

All clinical records of discharged residents shall be completed promptly and shall be filed and retained in accordance with State law.

(1) The discharge summary sheet shall contain the resident's name, address, dates of admission and discharge and a summary of the treatment and medication rendered during the resident's stay.

(2) The licensee of the facility shall be responsible for the retention and storage of medical records for the required length of time.

(3) In the event the facility transfers ownership or discontinues operations, the new licensee shall be responsible for the retention and storage of medical records for the required length of time.

805. TRANSFER OF RECORDS

If the resident is transferred to or from another health care facility, a copy of the resident's clinical record or an abstract thereof shall accompany the resident.

806. CONFIDENTIALITY OF RECORDS

All information contained in the clinical records is treated as confidential and shall be disclosed only to authorized persons.

807. STAFF RESPONSIBILITY FOR RECORDS

If the Intermediate Care Facility does not have a full or part-time medical record librarian, an employee of the facility shall be assigned the responsibility for assuring that records are maintained, completed, and preserved in accordance with accepted procedures. The designated individual is to be trained by a person skilled in record maintenance and preservation.

DIETARY SERVICES

900. GENERAL REQUIREMENT

The intermediate care facility shall have an organized dietary department under the direction of professionally qualified personnel to assure that:

(1) Good nutritional standards and daily dietary needs of residents are met.

(2) Medically prescribed special diets or dietary restrictions are professionally planned and supervised.

The intermediate care facility shall provide facilities to meet the general and special dietary needs of the residents.

901. DIRECTOR OF DIETARY SERVICES

(1) The dietary services shall be under the full-time direction of either:

(a) a qualified ADA dietitian,

(b) if ADA not available, a person with a Bachelor's Degree from an approved college or university with courses in foods and nutrition, dietetics, quantity food service, or institutional management (including courses in human nutrition and diet therapy), or

(c) an associate degree dietary technician with course study of at least two years consisting of food and nutrition, dietetics, quantity food service or institutional management, or

(d) a person with prior experience in food service management or preparation.

Note: If the dietary services are under the direction of (b) or (c), or (d), the facility shall provide at least 8 hours monthly for consultation services of an ADA qualified dietitian.

(2) The functions of the Director of Dietary Services shall consist of the following as a minimum:

(a) the development, maintenance and evaluation of all dietary policies and procedures,

(b) the employment, orientation, direction and supervision of all dietary personnel,

(c) the provision of nutrition consultation and in-service education for the nursing and other related staff,

(d) the participation in regular conferences with the Administrator, attending physician and Director of Nursing Service regarding dietary services,

(e) the making of recommendations and participation in the purchase, quantity and quality control of foods and equipment for the dietary service.

(3) Outside Food Management:

In facilities where the dietary services are provided under contract to an outside food management company, the company must have a dietitian in accordance with Section 901, who shall maintain standards as listed herein and provide for continuing liaison with the medical and nursing staff of the facility for recommendations on dietetic policies affecting resident care.

902. DIETARY STAFF

(1) The number of food service personnel, in addition to the Director, shall be determined by the size and needs of the facility.

(2) Food service personnel shall be on duty for a period of 12 hours or more daily.

(3) During the absence of the Dietary Services Director, a qualified member of the dietary staff shall be assigned to be in charge of the dietary services.

(4) In the event that dietary employees are assigned duties outside the dietary department, these duties shall not interfere with the sanitation, safety, or time required for dietary work assignments.

(5) Written job descriptions and qualifications of dietary employees shall be available at the facility for review.

903. WRITTEN POLICIES AND PROCEDURES

There shall be written policies and procedures for food storage, preparation and service developed by the ADA qualified dietitian which shall include, but not be limited to the following, and shall be available at the facility for review.

(1) Work assignments and duty schedules of all dietary personnel shall be posted.

(2) Food service personnel shall be in good health, practice hygienic food handling techniques, and shall meet the following requirements, as a minimum:

(a) food service personnel shall wear clean, washable garments, hair nets or clean caps, and keep their hands and fingernails clean at all times.

(b) routine health examinations shall meet local, State or Federal codes for food service personnel.

(c) food handlers' permits shall be current where required.

(d) personnel having symptoms of communicable diseases or open infected wounds shall not be permitted to work.

(3) The food and nutritional needs of residents shall be met in accordance with physicians' orders and, to the extent medically possible, meet the dietary allowances of the Food and Nutrition Board of the National Research Council, adjusted for age, sex and activity. (Reference: Food and Nutrition Board of the National Research Council.)

(4) Therapeutic diets ordered by physicians shall be planned, prepared and served under the direction of a qualified dietitian.

NOTE: Each individual resident's reaction and other pertinent information related to the therapeutic diet, shall be recorded in the resident's medical record by the nursing staff.

(5) A current New Jersey Diet Manual shall be maintained in the facility and be readily available to all personnel.

(6) At least three meals, or their equivalent, shall be served daily, at regular times, with no more than a 14-hour span between the evening meal and breakfast. Between-meal or bedtime snacks of nourishing quality shall be offered. If the "four or five meal a day" plan is in effect, meals and snacks shall provide equivalent nutritional value.

(7) Menus shall be planned at least two weeks in advance and food sufficient to meet the nutrition needs of residents shall be prepared as planned for each meal and when changes in the menu are necessary, substitutions shall provide equal nutritive value and so recorded on the menu.

(8) The current menu shall be posted in one or more accessible places in the dietary department for easy use by workers purchasing, preparing and serving foods.

(9) Menus shall provide a sufficient variety of foods served in adequate amounts at each meal, with different menus for the same days of each week adjusted for seasonal changes.

(10) Records of menus served shall be filed and maintained for 30 days.

(11) Supplies of staple foods for a minimum of a one-week period and of perishable foods for a minimum of a two-day period shall be maintained on the premises properly stored.

(12) Records of food purchases shall be kept on file.

(13) Foods shall be prepared by methods that conserve nutritive value, flavor, appearance, and shall be attratively served at the proper temperatures and in a form to meet individual needs.

(14) A file shall be maintained of tested recipes, adjusted to appropriate yield; food shall be cut, chopped or ground to meet individual needs and substitutes shall be offered to residents who refuse foods served.

(15) Effective equipment shall be provided and procedures established to maintain food at proper temperature during serving.

(16) Dining service shall be provided for all residents who can and will eat at a table.

(17) Trays provided bedfast residents shall rest on firm supports such as overbed tables and sturdy tray stands of proper height shall be provided residents able to be out of bed.

(18) Sanitary conditions shall be maintained in the storage, preparation and distribution of food; effective procedures for cleaning all equipment and work areas shall be followed consistently.

(19) Dishwashing procedures and techniques shall be established, understood and carried out in compliance with the State Sanitary Code.

(20) Written reports of inspections made by State or local health authorities shall be available at the facility for review.

(21) Waste which is not disposed of by mechanical means shall be kept in leak-proof non-absorbent containers with close fitting covers and shall be removed from the kitchen daily; containers shall be thoroughly cleaned inside and out and disinfected as needed.

(22) Dry or staple food items shall be stored in covered containers off the floor in a ventilated room not subject to sewage or waste water back-flow, or contamination by condensation, leakage, rodents or vermin.

904. DIETARY FACILITIES

(1) Dietary areas shall be provided for the general dietary needs of the institution/ which shall include an area or areas for the preparation of special diets and dining with table service.

(a) all dietary areas shall be appropriately located, adequate in size, well lighted, ventilated and maintained.

(b) the type, size and layout of equipment shall provide for ease of cleaning, optimal work flow, and adequate food production to meet the scope and complexity of the regular and therapeutic dietary requirements of the residents.

(c) equipment and work areas shall be clean and orderly with effective procedures for cleaning all equipment and work areas to safeguard the health of the residents.

(d) handwashing facilities, including hot and cold water, soap, and individual towels, preferably paper towels, are provided in or near kitchen areas.

CHAPTER 1000

OTHER ESSENTIAL SERVICES

1000. GENERAL REQUIREMENT

The Intermediate Care Facility shall have a program in effect to provide for the social, diversionary and spiritual needs of the resident, and such plan, with any subsequent alterations thereto, shall be available at the facility for review.

1001. SOCIAL AND DIVERSIONARY SERVICES

A condition for qualifying as an Intermediate Care Facility requires the facility to provide constructive care directed toward restoring and maintaining each resident at his best possible functional level.

1001.1 DIVERSIONARY PROGRAM

(1) The planned social and diversionary program shall include activities suited to the needs and interests of residents as an adjunct to the active treatment program of restoration and self-care. The aim shall be to encourage the resident to resume normal activities of daily living.

(2) The program shall use to the fullest extent possible, community, social and recreational resources.

(3) The facility shall provide for an adequate recreational area and recreational supplies.

(4) Activities shall be planned to provide group involvement and participation to stimulate socialization and remotivation.

(5) Residents shall be encouraged but not compelled to participate in group activities.

(6) Visiting hours shall be posted in the facility and provide for evening as well as afternoon visits, without restriction on visiting hours for a crisis or emergency.

1002. SPIRITUAL SERVICES

1002.1 PROVISION FOR SPIRITUAL SERVICES

The facility shall provide for meeting the spiritual needs of patient-residents by:

(1) Imposing no religious beliefs or practices on the patient-residents.

(2) Advising the appropriate clergymen of the patient-residents' admission to the facility and informing him, when necessary, of the resident's condition.

(3) Permitting the clergy reasonable access to residents.

(4) Providing space for private consultations with clergymen.

1002.2 REGULAR DEVOTIONAL SERVICES

The facility shall provide for holding regular devotional services on the premises and the staff shall encourage and assist the residents as is necessary to attend.

CHAPTER 1100

PHYSICAL FACILITIES

1100. GENERAL REQUIREMENT

The facility must be constructed, equipped, maintained and operated in compliance with all applicable Federal, State and local laws and regulations affecting the health and safety of the residents and their protection against the hazards of fire and other disaster.

1101. LIFE SAFETY CODE

The intermediate care facility, except as indicated in Section 1102 must meet such provisions of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) as are applicable to intermediate care facilities, except that the Division may waive in accordance with regulations of the Secretary of Health, Education and Welfare for such periods as it deems appropriate specific provisions of such code which, if rigidly applied, would result in unreasonable hardship upon an intermediate care facility, but only if the Division finds on the basis of documented evidence derived from a survey that:

(1) Such provision(s), if rigidly applied, would result in unreasonable hardship upon the intermediate care facility, and

(2) The waiver of the specific provision(s) does not adversely affect the health and safety of the residents in the facility and a written justification of such determination is maintained on file, and

(3) Where structural changes in the facility are necessary to meet a provision, the change is of such magnitude as to be infeasible or economically impracticable, delay in making such changes would not adversely affect the health and safety of residents, and an explanation of this findings is maintained on file, and

(4) The Division waives the provision(s) only upon assurance that the conditions of the waivers, cited above, are redetermined at the time of each survey of the intermediate care facility and written evidence of such redetermination is maintained on file, and

(5) The waiver of the requirement(s) is rescinded at any time any of the conditions of items (1), (2), (3) and (4) above are found no longer to apply.

1102. STATE FIRE AND SAFETY CODE

Intermediate care facilities shall be required to meet the provisions of the Life Safety Code unless the Division of Medical Assistance and Health Services finds that the fire and safety code imposed by State law adequately protects residents in intermediate care facilities.

1103. SAFETY CONDITIONS

The intermediate care facility shall be constructed, equipped and maintained to insure the safety of residents and provides a functional, sanitary and comfortable environment. The following standards shall be used to evaluate existing structures which do not meet the U.S. Public Health Service Construction Standards for a Long Term Care Facility. They are to be applied to existing construction with discretion and in light of community need for service.

(1) The facility shall comply with all applicable State and local codes governing construction, except in existing facilities where waivers are applicable.

(2) Fire resistance and flamespread ratings of construction materials and finishes shall comply with current State and local fire protection codes and ordinances.

(3) Permanently attached automatic fire-extinguishing systems of adequate capacity are installed in all areas considered to have special fire hazards including, but not limited to boiler rooms, trash rooms and nonfire resistant areas or buildings. In an intermediate care facility of two or more stories, fire alarm systems providing complete coverage of the building shall be installed and inspected regularly. Fire extinguishers

shall be conveniently located on each floor and in special hazard areas such as boiler rooms, kitchens, laundries and storage rooms. Fire regulations shall be prominently posted and carefully observed.

(4) Doorways, passageways and stairwells shall be wide enough for easy evacuation of patient-residents and shall be kept free from obstruction at all times. Corridors shall be equipped with firmly secured handrails on each side. Stairwells, elevators and all vertical shafts with openings shall have fire doors kept normally in a closed position. Exit facilities shall comply with State and local codes and regulations.

(5) Unless the facility is of fire resistive construction, blind and nonambulatory or physically handicapped persons shall not be housed above the street level floor.

(6) Reports of periodic inspections of the structure by the fire authority having jurisdiction in the area shall be on file in the facility.

(7) The building shall be maintained in good repair and kept free of hazards, such as those created by any damaged or defective parts of the building.

(8) No occupancies or activities undesirable to the health and safety of the residents shall be located in the building or buildings of the intermediate care facility.

1104. ENVIRONMENT CONDITIONS

The intermediate care facility shall be equipped and maintained to provide a functional, sanitary and comfortable environment. Its electrical and mechanical systems, including water supply and sewage disposal, shall be designed, constructed and maintained in accordance with recognized safety standards and shall comply with applicable State and local codes and regulations.

(1) Lighting levels in all areas of the facility shall be adequate and void of high brightness, glare and reflecting surfaces that produce discomfort. Lighting levels shall be in accordance with recommendations of the Illuminating Engineering Society. The use of candles, kerosene oil laterns and other open flame methods of illumination is prohibited.

(2) An emergency electrical service, which may be battery operated if effective for 4 or more hours, shall cover lights at nursing stations, telephone switchboard, night lights, exit and corridor lights, boiler room and the fire alarm system.

(3) The heating and air-conditioning systems, if applicable, shall be capable of maintaining adequate temperatures and providing freedom from drafts.

(4) An adequate supply of hot water for resident use shall be available at all times. Temperature of hot water at plumbing fixtures used by residents shall be automatically regulated by control valves and shall not exceed 110°F.

(5) The facility shall be well-ventilated through the use of windows, mechanical ventilation or a combination of both. Rooms and areas which do not have outside windows and which are used by residents or personnel shall be provided with functioning mechanical ventilation to change the air on a basis commensurate with the type of occupancy.

(6) All inside bathrooms and toilet rooms shall have forced ventilation to the outside.

(7) Laundry facilities, when applicable, shall be located in areas separate from resident units and shall be provided with necessary washing, drying and ironing equipment.

1105. ELEVATORS

Elevators shall be installed in the facility if resident bedrooms are located on floors above the street level.

(1) The installation of elevators and dumbwaiters shall comply with all applicable codes.

(2) Elevators shall be of sufficient size to accommodate a wheeled stretcher.

(3) A service contract for elevators shall be on file at the facility and available for review.

1106. RESIDENT NURSING UNIT

Each resident unit shall have at least the following basic service areas: Nurses' station, medicine storage and preparation area, space for storage of linen, equipment and supplies and a utility room.

(1) The nurses' call system shall register calls at the nurses' station from each resident bed, resident toilet room and each bathtub or shower.

(2) Equipment necessary for charting and recordkeeping shall be provided.

(3) The medication preparation area shall be well-illuminated and provided with hot and cold running water.

(4) The utility room shall be located, designed and equipped to provide areas for the separate handling of clean and soiled linen, equipment and supplies.

(5) Toilet and handwashing facilities shall be provided.

1107. RESIDENTS' BEDROOMS AND TOILET FACILITIES

Residents' bedrooms shall be designed and equipped for adequate care and the comfort and privacy of

residents. Each bedroom has or shall be conveniently located near adequate toilet and bathroom facilities. Each bedroom shall have direct access to a corridor and outside exposure with the floor at or above grade level.

(1) Ordinarily, rooms shall have no more than four beds with not less than 3 feet between beds and at the foot of beds.

(2) In addition to basic resident care equipment, each resident unit shall have a nurses' call signal, an individual reading light, bedside cabinet, comfortable chair and storage space for clothing and other possessions. In multiple bedrooms, each bed shall have flameproof cubicle curtains or their equivalent.

(3) Each resident room shall have a lavatory with both hot and cold running water, unless provided in adjacent toilet or bathroom facilities.

(4) On floors where wheelchair residents are located, there shall be at least one toilet room large enough to accommodate wheelchairs.

(5) Each bathtub or shower shall be in a separate room or compartment which is large enough to accommodate a wheelchair and attendant.

(6) At least one water closet, enclosed in a separate room or stall, shall be provided for each eight beds.

(7) Substantially secured grab bars shall be installed in all water closet and bathing fixture compartments.

(8) Doors to resident bedrooms shall never be locked.

1108. FACILITIES FOR ISOLATION

Provision shall be made for isolating infectious residents in well ventilated, single bedrooms having separate toilet and bathing facilities pending transfer to another facility. Such facilities shall also be available to provide for the special care of residents who develop acute illnesses while in the facility and residents in terminal phases of illness.

1109. EXAMINATION ROOMS

If provided, a special room(s) for examinations, treatments and other therapeutic procedures.

shall be of sufficient size and equipped with a treatment table, lavatory or sink with other than hand controls, instrument sterilizer, instrument table and necessary instruments and supplies.

1110. DAYROOM AND DINING AREA

The intermediate care facility shall provide one or more attractively furnished multipurpose areas of adequate size for resident dining, diversional and social activities.

(1) At least one dayroom or lounge, conveniently located, shall be provided to accommodate the diversional and social activities of the residents. In addition, several smaller dayrooms, convenient to resident bedrooms, are desirable.

(2) Dining areas shall be large enough to accommodate all residents able to eat out of their rooms. These areas shall be well-lighted and well-ventilated.

(3) If a multipurpose room is used for dining and diversional and social activities, there shall be sufficient space to accommodate all activities and prevent their interference with each other.

1111. KITCHEN OR DIETARY AREA

The intermediate care facility shall have a kitchen or dietary area adequate to meet food service needs and arranged and equipped for the refrigeration, storage, preparation and serving of food as well as for dish and utensil cleaning and refuse storage and removal. Dietary areas shall comply with local health or food handling codes. Food preparation space

shall be arranged for the separation of functions, located to permit efficient service to residents and not used for nondietary functions.

1112. BUILDING

Standards for design and construction shall conform to those promulgated by the U.S. Public Health Service for a Long-Term Care Facility and the New Jersey Standards for Construction of a Long Term Care Facility. These standards shall apply to all new construction:

(1) Whether a complete new intermediate care facility or an addition to an existing institution.

(2) The building shall be maintained in good repair and kept free of hazards at all times.

(3) Reports of inspections of the building shall be made by the Department of Health and shall be on file in the facility.

(4) If the facility is not of fire resistive construction, blind, non-ambulatory or physically handicapped persons shall be housed on the first floor.

1113. FIRE PROTECTION AND SAFETY

(1) Fire protective measures provided throughout the facility shall be in compliance with applicable sections of NFPA Standards No. 101, Life Safety Code, or as provided in Section 1102.

(2) Provision shall be made for immediate contact with the local fire department in case of a fire, preferably by direct alarm.

(3) A written report of a fire or any other unusual event shall be forwarded as soon as possible to the Division and the Department of Health.

(4) Employees shall be instructed in the use of fire fighting equipment and in the rapid evacuation of the building.

(a) instruction shall be planned on a regular basis to accommodate changes in personnel. Under no circumstances shall such instruction be given less than annually.

(b) simulated drills shall be held at irregular intervals on all tours of duty. These shall be conducted on each shift at least three times a year.

(c) a record shall be maintained of staff performance, results of each drill held and the corrective measures taken to resolve any difficulties encountered.

(d) appropriate regulations and safety measures shall be instituted to eliminate possible fire hazards from smoking by patient-residents, visitors or personnel.

1115. FIRE EXTINGUISHERS

Adequate and appropriate fire extinguishers shall be readily accessible in all areas of the facility. These shall be checked annually and shall be labeled with the date of the last inspection.

1116. REPORTS AND REGULATIONS

A written report of unusual incidents and accidents occurring to a resident, employee, visitor or other person shall be forwarded to the Division and the Department of Health.

1117. OXYGEN CYLINDERS

Oxygen cylinders shall be stored in a well ventilated area and shall be secured against toppling. Tanks of compressed gases shall not be covered with cotton or plastic material at any time.

1118. LIGHTING AND VENTILATION

(1) Artificial lighting shall be by electricity only.

(2) Adequate and satisfactory lighting levels shall be maintained in all areas of the facility.

(3) All residents' rooms, corridors, bathrooms and stairways shall be provided with night lights.

(4) All areas used by residents and personnel shall be provided with proper ventilation.

1119. HEATING

The heating plant shall be capable of maintaining a minimum temperature of 75 degrees Fahrenheit during the coldest weather.

1120. SANITATION

(1) The water supply shall be of safe and sanitary quality suitable for drinking purposes and shall be obtained from a water supply which conforms with the policies of the State Department of Health.

(2) An adequate supply of hot water shall be available for resident use at all times. Temperature of hot water at plumbing fixtures used by residents shall be automatically regulated and shall not exceed 110° Fahrenheit.

(3) Sewage shall be disposed of in accordance with the requirements of the local ordinances and the standards of the local and State Department of Health.

1121. PHYSICAL THERAPY

If provided, the physical therapy section of an intermediate care facility should have quarters of sufficient size to permit provision of parallel bars, shoulder wheel, steps with rail, posture mirror and any other equipment essential to carry out the orders of individual physicians. The physical therapy

unit should also have hand rails around all walls for protection of patient-residents. The intermediate care facility shall also provide such cubicle curtaining as is essential to provide proper privacy as needed by residents receiving treatments.

CHAPTER 1200

HOUSEKEEPING SERVICES

1200. GENERAL REQUIREMENT

The Intermediate Care Facility (~~[illegible]~~) shall provide the housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment.

1201. HOUSEKEEPING STANDARDS

(1) The Administrator of the facility shall see that housekeeping services are provided ~~which/shall be~~ adequate to maintain, clean, safe and orderly surroundings for residents and personnel.

(2) A work plan for cleaning operations shall be established and kept on file in the facility.

(3) Housekeeping personnel shall be trained in acceptable procedures of cleaning.

(4) Safety aspects of good housekeeping practice shall be followed by all personnel.

(5) Adequate cleaning equipment and supplies shall be provided for all housekeeping procedures required within the facility.

1201.1 PRACTICES AND PROCEDURES

The facility shall provide sufficient housekeeping and maintenance personnel to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. Nursing personnel shall not be assigned housekeeping duties.

(1) Housekeeping personnel shall keep the facility free from offensive odors, dirt, rubbish, dust and hazards to safety.

Deodorizers shall not be used to cover up odors caused by unsanitary conditions or poor housekeeping practices.

Storage areas, attics and cellars shall be kept safe

and free from accumulations of extraneous materials such as refuse, discarded furniture and old newspapers. Combustibles such as cleaning rags and compounds shall be kept in closed metal containers.

(2) Floors shall be cleaned regularly. Polishes on floors shall provide a nonslip finish and throw or scatter rugs shall not be used except for nonslip entrance mats.

(3) Walls and ceilings shall be maintained free from cracks and falling plaster and shall be cleaned and painted regularly.

(4) The grounds shall be kept free from refuse and litter. Areas around buildings, sidewalks, gardens and patios shall be kept clear of dense undergrowth.

1201.2 PEST CONTROL

The facility shall be maintained free from insects and rodents.

(1) A pest control program shall be in operation in the facility. Pest control services shall be provided by maintenance personnel of the facility or by contract with a pest control company. Care shall be taken to use the least toxic and least flammable effective insecticides and rodenticides. These supplies shall be stored in non resident areas and in nonfood preparation and storage areas. Poisons shall be kept under lock.

(2) Windows and doors shall be appropriately screened during the insect breeding season.

(3) Harborages and entrances for insects and rodents shall be eliminated.

(4) Garbage and trash shall be stored in areas separate from those used for the preparation and storage of food and shall be removed from the premises in conformity with State and local practices. Containers shall be cleaned regularly.

1201.3 LINEN

The facility shall have available at all times a quantity of linen essential for the proper care and comfort of residents. Linens shall be handled, stored and processed so as to control the spread of infection.

(1) The linen supply shall be at least three times the usual occupancy.

(2) Clean linen shall be stored in clean, dry, dust-free areas easily accessible to the nurses' station.

(3) Soiled linen shall be stored in separate well ventilated areas and shall not be permitted to accumulate in the facility. Soiled linen and clothing shall be stored separately in suitable bags or containers.

(4) Soiled linen shall not be sorted, laundered, rinsed or stored in bathrooms, resident rooms, kitchens, or food storage areas.

CHAPTER 1300

DISASTER PLAN

1300. GENERAL REQUIREMENTS

The facility must have a written procedure to be followed in case of fire, explosion or other disaster. The procedure must specify persons to be notified, locations of alarm signals and extinguishers, evacuation routes, procedures for evacuating helpless patient-residents, frequency of fire drills and assignments of specific tasks and responsibilities to personnel for each drill.

(1) The plan shall be developed with the assistance of qualified fire and safety experts.

(2) Simulated drills testing the effectiveness of the plan shall be conducted on each shift at least three times a year with a written record of such drills which includes the date, hour, description of drill, staff participation and person in charge.

(3) The plan shall be posted throughout the facility.

Nursing Services

1400. General Requirements

1. The Intermediate Care Facility shall provide 24 hour nursing services, 7 days per week for a minimum of 1-1/4 hours each day for each resident.

2. The nursing services shall be under the direction of a Registered Professional Nurse employed for a minimum of 35 hours a week whose function shall be primarily administrative and whose time shall be counted in the 1-1/4 hours of nursing service on the following basis:
(a) A facility up to 20 beds may credit 50% of the time.
(b) A facility from 20-29 beds may credit 33 1/3% of the time.
(c) A facility from 30-39 beds may credit 25% of the time.

3. There shall be, in addition to the Director of Nursing Services, sufficient licensed nurses on duty to provide 20% of the minimum required 1-1/4 hours of care for each resident in every 24 hour period; 80% of the minimum required hours of care may be provided by nurses' aides.

4. There shall be, on duty, no less than one registered professional nurse or licensed practical nurse for 8 hours on the day shift/ and for 8 hours o the evening shift seven days a week. / There shall also be at least one aide on duty for a span of eight hours on each shift (regardless of the size or census of the facility) for the purpose of giving direct resident care or supervision.

5. Nursing staff shall be distributed throughout each tour of duty and throughout the week according to the services and activities to be provided on certain days and times of day, while maintaining at all times sufficient nursing staff for adequate, safe care of residents.

6. There shall be a job description on file for each nursing title used in the facility which shall include the

general responsibilities for each category of nursing personnel.

7. Time sheets and payroll sheets for all nursing personnel shall be available to authorized personnel of the New Jersey State Department of Health and/or of the Department of Institutions and Agencies to show compliance with the standards for minimal and qualified nurse coverage.

1401. Nursing Staff Required

1. Director of Nursing Services

The Director of Nursing Service shall be a registered professional nurse with a minimum of two years experience in nursing service administration, nursing supervision, rehabilitation nursing, psychiatric, and/or geriatric nursing.

2. Nurse Supervisors and Head Nurses

There shall be sufficient nurse supervisors and head nurses to meet the needs of the facility in relation to its size and complexity and to the quantity and quality of other nursing staff employed.

3. Staff Nurses and Nurses' Aides

There shall be a sufficient number of staff nurses, nurses' aides and other nursing personnel to provide the required quantity and quality of direct nursing care.

1402. Administration of Medications

All medications will be administered to residents upon written order of the attending physician by a licensed nurse in accordance with the Nurse Practice Act of New Jersey, the regulations of the New Jersey Board of Nursing and the standards set forth in the sections on Physicians and on Pharmaceutical Services. Telephone orders are to be accepted only when necessary and only by licensed nurses. Telephone orders are to be written into the appropriate clinical record by the nurse receiving them and countersigned by the physician on his next visit.

1403. Equipment and Nursing Supplies

The following equipment and supplies will be made available by the facility:

A. Equipment necessary in each unit for providing proper care and treatment to all residents.

B. Equipment necessary for the proper storage and administration of medications.

C. First aid supplies and equipment with a breakable seal, kept at or near the nurses' station.

D. Provision for sterilization by autoclave or chemicals after each use of reusable equipment in accordance with accepted hospital techniques.

1404. Nursing Records and Reports

The following are the minimal records and reports required:-

A. Individual Nursing-Social Care Plan

The Nursing-Social Care Plan shall be an organized written plan for the nursing and social care of each resident indicating coordination of medical and nursing care with other planned activities directed toward established goals for restorative, maintenance and preventive health care, reviewed and revised according to individual resident requirements to all nursing and social personnel.

An essential aspect of these care plans is the inclusion of nursing direction to the nursing staff for special techniques and approaches to individual residents when carrying on the physician's orders, nursing, and/or social therapies so that the desired and/or effective results are obtained.

B. Medication Sheets

Medication sheets shall be a part of the clinical record of each resident and shall contain notation of each medication and treatments. These shall be kept in accordance with criteria established by the Pharmacy and Therapeutics Committee or other designated committee used by the facility.

The use of physical restraints ordered by the physician shall be recorded on the medication sheet showing the exact day and hours of each use, unless recorded in the same detail in the Nurses' Notes.

Individual records shall be maintained for each container of drug which is subject to the Controlled Substance Act of 1970 showing the use of each dose in compliance with all state and federal requirements

C. Nurses Notes and/or Daily Activities Records

1. Nurses' notes shall be kept at least monthly for each resident receiving nursing care and shall show progress toward goals of restoration and/or maintenance.

2. Temporary illness or sudden change in condition of a resident shall be cause for keeping a clinical record on all 3 tours of duty each 24 hour day until the resident's condition returns to previous level or to an apparent plateau no longer indicative of a need for frequent nurses' notes.

3. Daily Activities Records in order to show response to social care plans, shall be kept on each resident at least monthly, and more often as necessary when special progress toward a goal, or when obvious deterioration shows need for new approaches and/or new goals.

4. Physical Restraints ordered by the physician shall be recorded indicating type, date, shift, number of hours of each use, unless recorded on the Medication Sheet.

D. Accident Reports and Incident Reports

Special reports on designated forms shall be filed by nursing personnel involved in or witness to accidents and incidents which may involve a question of resident safety or be possible cause for subsequent question as to the adequacy of nursing-social care or supervision. These forms should be used in cases of known injury to residents received on the premises, evidence of possible injury from unknown cause, in medication errors, in resident physical altercations with each other, or with nursing staff. A copy of the accident report form shall be attached to the residents' record and a copy given to the administrator.

1405. Orientation of New Personnel and Continued Inservice Education for All Nursing and Social Personnel

Under the supervision of the Director of Nursing Services the following is required:

A. Established procedure and recorded content for the orientation of all new nursing and social personnel to the particular health care facility and its philosophy of care, and to the specific functions and duties to be performed.

B. Continuing Inservice Education for all nursing personnel, to include:-

1. Current theory appropriate to each level of nursing staff in medical, geriatric, psychiatric, and restorative nursing, and social care.

2. Instruction in planning and conducting individual and group social and recreational activities and in adaptation of environmental factors to meet the physical and psychosocial needs of the residents.

3. Instruction in accident prevention and infection control.

1406. Ancillary Services

A. Activities Program

A structural activities program shall be provided each resident unless preempted by order of the attending physician. Other social and recreational activities shall be available regularly to all residents, which involves active participation and includes community activities, as is possible and appropriate in character and frequency to the residents' individual capacities.

The nursing staff shall participate at their appropriate levels to the extent necessary to supplement recreational staff in promoting and/or cooperating in the provision of an activities program which will reinforce the goals of restoration and maintenance of physical, mental and social function of patient-residents.

B. Social Work Services

Nursing staff shall cooperate with the social work staff, if available, and/or the social work consultant to the facility, if available, and with social work staff of the county welfare boards, to ensure effective total care planning for each resident.

PHARMACEUTICAL SERVICES

1500. GENERAL REQUIREMENT

All drugs and medications must be prescribed, handled, stored, and administered in accordance with the requirements of this manual and all other applicable State and Federal regulations.

1501. STANDARDS FOR PHARMACEUTICAL SERVICES

The facility shall have written policies covering the pharmaceutical services which are developed with the advice of members of the medical staff, pharmacist and Director of Nursing Services, and which are reviewed at least annually. Pharmacy policies and procedures including obtaining, dispensing, and administering drugs and biologicals are to be developed by the medical staff, pharmacist, and Director of Nursing Services serving as the Pharmacy and Therapeutics Committee or other designated committee used by the facility.

1502. SPECIFIC REQUIREMENTS

(1) The services of a consultant pharmacist shall be provided .

(a) the consultant pharmacist shall visit the facility as required, but least bi-monthly and shall provide the Administrator with a monthly written report of his findings;

(b) the consultant pharmacist is responsible for the control of all bulk drugs and maintains records of their receipt and disposition;

from the drug supply, properly label them and make them available to appropriate licensed nursing personnel. Wherever possible, the pharmacist, in dispensing drugs, works from the prescriber's original order or a direct copy.

1503. EMERGENCY KIT

An emergency kit approved by the Pharmacy and Therapeutics Committee or other designated Committee used by the facility, shall be provided in the drug room.

The emergency kit shall have a breakable seal placed in such a manner that it will readily indicate that the kit has been opened. This kit shall be maintained, restocked and resealed by the consultant pharmacist as needed, but at least monthly. All medications shall be injectables (unit packaged) with the exception of aromatic ammonia spirits and nitroglycerine tablets.

Emergency drugs may be administered by a licensed nurse in the presence of a licensed physician, by the physician, or by telephone order from the physician.

The following items are suggested as minimal for an acceptable emergency kit:

Adrenalin 1:1000	1 c.c. amp.
Atropine 0.4 (1/150)	(B.W.) 0.5 c.c. amp.
0.5 mg.	(B.W.) 1 c.c. amp.
1.0 mg.	(Wyeth) 1 c.c. amp.
Cedilanid D 0.2 mg/cc.	2 c.c. amp.
Isuprel 1:5000	1 c.c.& 5 c.c. amp.
Levophed 0.2%	4 c.c. amp.
Lorfan 1 mg/cc.	1 c.c. amp.
Neosynephrine 1% (10 mg/cc.)	1 c.c. amp.
Quinidine SO_4 (Gluconate in multiple only)	
Quinidine SO_4 (3 gr.) 200 mg/cc.	1 c.c. amp.
Sodium Bicarbonate	50 c.c. amp.
Corticosteroid	
Decadron (also in disposable syringe)	1 c.c. (syr.)
4 mg/cc.	1 c.c. amp.
Vitamin K - Synkavite - 5 mg/cc.	1 c.c. amp.
Synkavite - 10 mg/cc.	1 c.c. amp.
Aquamephyton - 10 mg/cc.	1 c.c. amp.
Digitalis - Lanoxin (Digoxin)	
0.1 mg/cc.	1 c.c. amp
0.5 mg/2 cc.	2 c.c. amp.
Purodigin - 0.2mg/cc.	1 c.c. amp.
Antihistamine - Benadryl 50 mg/cc.	1 c.c. amp.
Phenergan 25 mg/cc.	1 c.c. amp.
Phenergan 50 mg/cc.	1 c.c. amp.
CTM 10 mg/cc.	1 c.c. amp.
Lidocaine (Xylocaine) 1%	2 c.c. amp.
Diuretic - Mercuhydrin	1 c.c. amp.
Lasix 20 mg/2 c.c.	2 c.c. amp.
Sparine (Tubex) 25 & 50 mg/cc.	1 c.c. amp.

Acceptable Diuretic	1 vial
Aromatic Spirits of Ammonia 1 oz.	1 bottle
Nitroglycerine Tablets 1/200 gr., 100's	1 bottle

3 Rotating Tourniquets

1 Tourniquet

1 50cc Syringe (Disposable)

2 files

1 Adult Resuscitube

1 Child Resuscitube

6 2x2 Gauze Pads

6 3x3 Gauze Pads

6 4x4 Gauze Pads

3 2cc Sterile Syringes (Disposable)

3 5cc Sterile Syringes (Disposable

2 25cc Sterile Syringes with #25 Gauge Needles attached (Disposable)

1 #18 Gauge Needle - 1-1/2"

1 #18 Gauge Needle - Angiocath

1 #21 Gauge Needle - Scalpvein

2 #20 Gauge Needles - 3" Intracardiac

6 #26 Gauge Needles - 1/2" (Disposable)

1 Antiseptic Solution

1 Pair Sterile Gloves

1 30cc Syringe (Disposable)

1 Airway Medium Oral

4 Alcohol Sponges (pre-wrapped)

1 Knife Blade & Handle (Disposable)

1 Tongue Blade - Padded (Disposable)

1 Sterile Levin Tube (Disposable)

1 Bulb Syringe

2 Gauge Needles - 1-1/4"

04. CONFORMANCE WITH PHYSICIAN'S ORDERS

(1) All medications administered to residents are ordered, in writing, on the resident's chart by the resident's physician and shall be in effect for the specified number of days indicated by the physician but in no case to exceed 60 days. Oral orders are given only to a registered professional nurse or licensed practical nurse, immediately reduced to writing, signed by the nurse and countersigned by the physician at his next visit. Medications not specifically limited as to time or number of doses, when ordered, are automatically stopped in accordance with written policy approved by physician or physicians responsible for advising the facility on its medical administrative policies.

EMERGENCIES: In the event of an emergency telephone order where the life of the resident may be endangered or his clinical status may be compromised, such order must be countersigned by the physician within 12 hours from the time the order was given.

(2) If the quantity of sustaining drug or maintenance medication is not indicated in writing by the physician, the pharmacy provider must dispense a minimum of 100 tablets or capsules, a pint, or a 30-day supply, whichever is less. Maintenance medication is defined as any drug used continuously. (i.e., daily, TID, every other day, etc.) for 14 days or more.

1505. STOP ORDER POLICY

The resident's attending physician shall be notified of stop order policies by the Pharmacy and Therapeutics Committee and contacted promptly by the head nurse, for renewal of such orders prior to expiration of such order to that continuity of the resident's therapeutic regimen is not interrupted.

The following shall be considered a guideline for a stop order policy:

Analgesics	-2 weeks
Antianemia	-1 month
Antibiotics	-5 days
Anticoagulants	-Automatic
Antiemetics	-3 days
Antihistamines	-2 weeks
Antineoplastics	-1 week
Barbiturates	-1 month
Cardiovascular Drugs	-1 month
Cathartics	-1 month
Cold Preparations	-5 days
Cough Preparations	-5 days
Dermatologicals	-1 week (except emollients)
Diuretics	-1 month
Hormones	-1 month
Hypnotics	-1 month
Narcotics	-5 days
Psychotherapeutics	-1 month
Sedatives	-1 month
Spasmolytics	-2 weeks
Sulfonamides	-5 days
Vitamins	-1 month

1506. ADMINISTRATION OF MEDICATIONS

All medications shall be administered or supervised by licensed medical or nursing personnel in accordance with the Medical and Nurse Practice Acts of New Jersey. Each dose administered shall be properly recorded on the resident's clinical record in accordance with the following criteria:

(1) The nursing station(s) shall have readily available items necessary for the proper administration of medication.

(2) Medications shall be administered by nursing personnel in accordance with the requirements in Chapter 1400 on Nursing Services.

(3) Medications prescribed for one resident shall not be administered to any other resident except in extreme emergency.

(4) Self-administration of medications by residents shall not be permitted except for emergency drugs on special order of the resident's physician or in a predis-charge program under the supervision of a licensed nurse.

(5) Medication errors and drug reactions shall be immediately reported to the resident's physician and an entry thereof made in the resident's clinical record as well as on an incident report, and signed by the attending physician.

(6) Up-to-date medication reference texts and sources of information shall be provided. Any one of the following texts shall be considered acceptable as a minimum:

American Hospital Formulary Service

American Drug Index

Facts and Comparisons

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Physicians' Desk Reference

(7) Medications shall be administered and properly recorded on the resident's clinical record by the same nurse and shall include each dosage given, method of administration, time and full signature of the nurse.

1507. RECEIPT OF MEDICATION FROM PHARMACY PROVIDER

There shall be assigned a responsible person(s) by the facility whose signature(s) on the pharmacy provider's claim form will attest to receipt of any medications supplied to the facility. The signature(s) of such person(s) vested with this responsibility shall be on file with the State Agency responsible for maintenance of standards.

1508. LABELING AND STORING

(1) Resident's medications shall be properly labeled and stored in a locked cabinet or room at the nurse's station in accordance with the following criteria:

(a) the label of each resident's individual medication container clearly indicates the resident's full name; physician's name; prescription number; name, strength and quantity of drugs; directions for drug use; name, address and telephone number of pharmacy issuing the drug; the manufacturer's name with the lot or control number of the medication.

(b) medication containers having soiled, damaged, incomplete or makeshift labels shall be returned to the issuing pharmacy for relabeling or disposal. Medication in containers having no labels or illegible labels or medications no longer in use, or medications whose expiration date is past, shall be destroyed in accordance with State and Federal laws.

(c) the medications of each resident are stored in their originally received containers. Transferring between containers is forbidden.

(d) separately locked, securely fastened boxes (or drawers) within the medicine cabinet shall be provided for storage of narcotics, barbiturates, amphetamines and other dangerous drugs as provided for Schedule II Drugs under the Controlled Substances Act of 1970. Narcotic drugs, Schedules III, IV and V Drugs as indicated by the Controlled Substances Act shall be retained under double lock at all times.

(e) cabinets shall be well lighted and of sufficient size to permit storage without crowding;

(f) medications requiring refrigeration shall be kept in a separate, locked box within a refrigerator at or near the nursing station except in a locked drug room;

(g) poisons and medications for "external use only" shall be kept in a locked cabinet and separate from other medications and properly labeled.

(h) only supplies of non-legend drugs may be maintained as stock and must be administered by individual order of the resident's physicians. Non-legend drugs may be administered by a registered professional nurse or a licensed practical nurse directly from a stock supply.

1509. CONTROL OF DRUGS SUBJECT TO CONTROLLED SUBSTANCE ACT OF 1970

(1) Narcotics

(a) the facility shall comply with all Federal and State laws and regulations relating to the procurement, storage, dispensing, administration and disposal of narcotics and those drugs subject to the Controlled Substances Act of 1970.

(b) A narcotic record shall be maintained, listing on separate sheets for each type and strength of narcotic

the following information: Date, time administered, route of administration, name of patient-resident, dose, prescribing physician's name, signature of person administering dose and balance of the medication remaining.

(2) Other Drugs

(a) there shall be full compliance with all Federal and State laws and regulations relating to the procurement, storage, dispensing, administration and disposal of all medications subject to the Controlled Substances Act of 1970.

(b) an individual record shall be maintained for each type and strength of medication subject to the aforementioned Act. The following information shall be recorded: Date, time administered, name of patient-resident, dose, route of administration physician's name, signature of the person administering the dose and the balance of the medication remaining.

(c) a record of the verification of inventories of the controlled medications shall be made by both nurses (incoming and outgoing) at the time of each tour change. Provision shall be made for established procedures to be followed in the event that the inventories cannot be verified. A report of all such incidents shall be written and signed by

both nurses and further investigation shall be made by the pharmacist and Administrator with subsequent written report to the appropriate Federal agency.

(d) suitable provisions shall be established for procedure to be instituted for controlled medications which may be lost, contaminated or destroyed. Such incidents shall be documented by the nurse involved and witnesse if present at the time, with a follow-up investigation to be made by the consultant pharmacist and Administra with subsequent written report to the appropriate Federal agency.

(3) The key to the medication room or cabinet shall be kept on the person of the registered professional nurse or licensed practical nurse authorized to administer medications on each tour of duty.

(4) The supply of needles and syringes used to administer medications to residents shall be stored in a locke area and disposable needles and syringes shall be destroyed after use in such a manner that they can no longer be used as a needle or syringe or provide injury to personnel. A record of the disposition shall be maintained at the facility

CHAPTER 1600

CIVIL RIGHTS

1600. PROHIBITIONS AGAINST DISCRIMINATION

All facilities receiving payments for intermediate care facility services under Title XIX are subject to all applicable Federal, State and local laws and regulations with respect to civil rights, including Title VI of the Civil Rights Act of 1964.

Section 601 of the Civil Rights Act of 1964 prohibits discrimination in any program or activity receiving Federal financial participation. The Federal Regulation promulgated pursuant to Title VI by the Department of Health, Education and Welfare prohibits the Division of Medical Assistance and Health Services, directly or through contractual or other arrangements, to subject an individual to segregation or separate treatment on the grounds of race, color or national origin in any matter related to his receipt of any aid, care, services or other benefits provided under the program. The Division must take such steps as necessary to assure that any other agency, institution or organization participating in the program, through contractual or other arrangements, will comply with the Act and Regulation.

Specifically, the Division, through its approved Title VI State Plan and Methods of Administration, has committed itself, in accordance with Federal policy, to secure an assurance of compliance and to conduct an annual compliance review of every intermediate care facility to which a vendor payment is made.

Compliance reviews of intermediate care facilities, which may be incorporated in visits for other purposes, should be evaluative of a facility's policies and practices in accordance with the following guidelines.

1601. GUIDELINES FOR COMPLIANCE

Section 601 of Title VI of the Civil Rights Act of 1964 states:

> "No person in the United States, shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Intermediate care facilities or similar facilities which are in compliance with Title VI of the Civil Rights Act are characterized by an absence of separation, discrimination or other distinction on the basis of race, color, or national origin in any activity conducted by, for, or in the institution affecting the care and treatment of residents.

Compliance with Title VI requires adherence to the following policies and practices.

1601.1 ADMISSION

(1) All residents are admitted to the facility without discrimination and no inquiries are made regarding race, color, or national origin prior to admission. The intermediate care facility utilizes its referral sources in a manner which assures an equal opportunity for admission to persons without regard to race, color, or national origin in relation to the population of the service area or potential service area.

(2) Admission is not restricted to members of any group or order which discriminates.

(3) Intermediate care facility policies regarding deposits, extension of credit and other financial matters are applied uniformly and without regard to race, color or national origin.

(4) Information regarding the price and availability of accommodations is uniformly made available to all without regard to race, color, or national origin.

1601.2 RECORDS

Records are maintained uniformly without discrimination for all residents. Identification by race, color and national origin on records is not considered to be discriminatory and may be used to demonstrate compliance with Title VI.

1601.3 SERVICES AND PHYSICAL FACILITIES

(1) Residents' privileges and care services such as medical and dental care; nursing; laboratory services; pharmacy; physical, occupational and recreational therapies; social services; volunteer services; dietary service and housekeeping services are provided on a nondiscriminatory basis.

(2) Physical facilities including lounges, dining facilities, lavatories and beauty and barber shops are provided and used without discrimination.

(3) Rules of courtesy are uniformly applied without regard to race, color, or national origin in all situations including face-to-face contact and written records and communications.

(4) Assignment of staff to residents is not governed by the race, color, or national origin of either patient-resident or staff.

(5) Intermediate care facilities which have dual facilities (buildings, waiting rooms, entrances, dining facilities, etc.) have a particular responsibility to demonstrate that such facilities are not operated in a discriminatory manner.

1601.4 ROOM ASSIGNMENT AND TRANSFERS

(1) Residents are assigned to rooms, wards, floors, sections, buildings and other areas without regard to race, color, or national origin. Such assignment will result in multi-racial occupancy of multi-bed accommodations which reflects the proportion of minority use of the facility.

(2) Residents are not asked whether they are willing to share accommodations with persons of a different race, color, or national origin. Requests are not honored if based on racial or ethnic considerations. Exceptions may be made only if the attending physician or nursing home administrator certifies in writing that in his judgment there are valid medical reasons or special compelling circumstances in the individual case. However, such certifications may not be used to permit segregation as a routine practice in the facility.

1601.5 ATTENDING PHYSICIANS' PRIVILEGES

Privileges of attending patients in the intermediate care facility are granted to physicians and other health professionals without discrimination.

1601.6 NOTIFICATION OF AVAILABILITY OF SERVICES AND NONDISCRIMINATION POLICY

(1) The intermediate care facility has adopted and where appropriate provided its residents, employees, attending physicians and other providing services to patient-residents, with copies of written statements which set forth the intermediate care facility non-discrimination policies and practices. These policies are included in any publication of staff regulations or public information brochures, kept current and periodically reviewed with employees.

(2) The intermediate care facility effectively conveys to the community, to hospitals and other referral sources, its non-discriminatory policy and the nature and extent of services available.

1601.7 REFERRALS

Intermediate care facility referrals, including but not limited to referrals to other facilities and care programs, are made in a manner which does not result in discrimination.

1602. FEDERAL REVIEW

Reports of compliance visits are subject to Federal review and the Regional Office for Civil Rights staff is available for technical assistance to the Division and other State agencies in carrying out compliance reviews.