

**N.J.A.C. 8:39**

**STANDARDS FOR LICENSURE OF  
LONG-TERM CARE FACILITIES**

**Effective date: November 20, 2017**

**TITLE 8. HEALTH  
CHAPTER 39. STANDARDS FOR LICENSURE OF LONG-TERM CARE  
FACILITIES**

**N.J.A.C. 8:39 (2017)**

**NOTE:** This is an unofficial version of the rules. The Official rules can be found in the New Jersey Administrative Code, as published by LexisNexis at N.J.A.C.8:39. Updates to the code are released through New Jersey Registrar also found for a fee on LexisNexis

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**N.J.A.C. 8:39****STANDARDS FOR LICENSURE OF  
LONG-TERM CARE FACILITIES****Effective date: November 20, 2017****TITLE 8. HEALTH  
CHAPTER 39. STANDARDS FOR LICENSURE OF LONG-TERM CARE  
FACILITIES****N.J.A.C. 8:39 (2017)****Title 8, Chapter 39 -- Chapter Notes****NOTES:**

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CHAPTER SOURCE AND EFFECTIVE DATE: Effective: December 23, 2013.

See: 46 N.J.R. 221(b).

**CHAPTER EXPIRATION DATE:**

Chapter 39, Standards for Licensure of Long-Term Care Facilities, expires on December 23, 2020.

**CHAPTER HISTORICAL NOTE:**

Chapter 39, Standards for Licensure of Long-Term Care Facilities, was adopted as R.1977 d.222, effective January 1, 1978. See: 9 N.J.R. 171(c), 9 N.J.R. 322(c).

Chapter 39, Standards for Licensure of Long-Term Care Facilities, was repealed and Chapter 39, Long-Term Care Facilities, was adopted as new rules by R.1983 d.236, effective June 20, 1983. See: 15 N.J.R. 279(a), 15 N.J.R. 1022(b).

Chapter 39, Long-Term Care Facilities, was repealed and Chapter 39, Manual of Standards for Long-Term Care, was adopted as new rules by R.1988 d.280, effective June 20, 1988. See: 20 N.J.R. 469(a), 20 N.J.R. 1432(a).

Pursuant to Executive Order No. 66(1978), Chapter 39, Manual of Standards for Long-Term Care, was readopted as R.1993 d.341, effective June 14, 1993. See: 25 N.J.R. 1474(a), 25 N.J.R. 2878(a).

Chapter 39, Manual of Standards for Long-Term Care, was repealed and Chapter 39, Standards for Licensure of Long-Term Care Facilities, was adopted as new rules by R.1994 d.582, effective November 21, 1994, operative January 1, 1995, except Subchapter 43, operative November 21, 1994. See: 26 N.J.R. 1772(c), 26 N.J.R. 4641(a). Pursuant to Executive Order No. 66(1978), Chapter 39 expired on November 21, 1999.

Chapter 39, Standards for Licensure of Long-Term Care Facilities, was adopted as new rules by R.2001 d.297, effective August 20, 2001. See: 32 N.J.R. 3003(a), 33 N.J.R. 2851(a).

Chapter 39, Standards for Licensure of Long-Term Care Facilities, was readopted as R.2007 d.83, effective February 15, 2007. As a part of R.2007 d.83, Appendices E and F were adopted as new rules, effective March 19, 2007. See: 38 N.J.R. 4141(a), 39 N.J.R. 924(a).

Subchapter 41, Mandatory Staff Posting and Reporting Standards, and Appendix G were adopted as new rules by R.2010 d.019, effective January 19, 2010. See: 41 N.J.R. 42(a), 42 N.J.R. 468(b).

Appendix C, Patient Information Transfer Form, was repealed; and Appendices D through G were recodified as C through F by R.2011 d.198, effective August 1, 2011 (operative October 30, 2011). See: 42 N.J.R. 1462(a), 43 N.J.R. 1875(a).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 39, Standards for Licensure of Long-Term Care Facilities, was scheduled to expire on February 15, 2014. See: 43 N.J.R. 1203(a).

Chapter 39, Standards for Licensure of Long-Term Care Facilities, was readopted, effective December 23, 2013. See: Source and Effective Date.

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## SUBCHAPTER 1. GENERAL PROVISIONS

### § 8:39-1.1 Scope and purpose

- (a) This chapter contains rules and standards intended to assure the high quality of care delivered in long-term care facilities, commonly known as nursing homes, throughout New Jersey. Components of quality of care addressed by these rules and standards include access to care, continuity of care, comprehensiveness of care, coordination of services, humaneness of treatment, conservatism in intervention, safety of the environment, professionalism of caregivers, and participation in useful studies.
- (b) These rules and standards apply to each licensed long-term care facility. They are intended for use in State surveys of the facilities and any ensuing enforcement actions. They are also designed to be useful to consumers and providers as a mechanism for privately assessing the quality of care provided in any long-term care facility.

### § 8:39-1.2 Definitions

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

"Actual hours worked" means the hours that a staff member is scheduled to work on the particular shift for which information is being reported.

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

"Advanced practice nurse" means a person certified by the New Jersey Board of Nursing in accordance with Section 8 or 9 of P.L. 1991, c.377; amended by P.L. 1999, c.85, § 6.

"Adverse drug reaction" means any unexpected, unintended, undesired or excessive response to a drug such that it:

1. Requires discontinuing the drug (therapeutic or diagnostic);
2. Requires changing the drug therapy;
3. Requires modifying the dose;
4. Negatively affects prognosis; or
5. Results in temporary or permanent harm or disability, or death.

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

"Bed" or "licensed bed" means one of the total number of beds for which each licensed long-term care facility is approved for resident care by the Commissioner of the New Jersey State Department of Health and Senior Services.

"Certified nurse aide" means an individual who has satisfied the requirements of N.J.A.C. 8:39-43.1(a).

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

"Commissioner" means the Commissioner of the New Jersey Department of Health and Senior Services, or his or her designee.

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

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

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

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

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

"Defibrillator" means a medical device heart monitor and defibrillator that has received approval of its pre-market notification filed pursuant to 21 U.S.C. § 360(k) from the United States Food and Drug Administration, is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia, is capable of determining, without intervention by an operator, whether defibrillation should be performed, and upon determining that defibrillation should be performed, automatically charges and requests delivery of an electrical impulse to an individual's heart.

"Department" means the New Jersey Department of Health and Senior Services.

"Dietitian" means a person who possesses a bachelor's degree from an accredited college or university with a major area of concentration in a nutrition-related field of study, and one year of full-time professional experience or graduate-level training in nutrition.

"Direct resident care" means clinical care services provided directly to residents by a registered professional nurse, licensed practical nurse and/or a certified nurse aide and the supervision of those providing clinical care services to residents.

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

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

"Drug administration" means a procedure in which a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such procedures. The complete procedure of administration includes:

1. Removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container);
2. Verifying it with the prescriber's orders;
3. Giving the individual dose to the resident;
4. Seeing that the resident takes it (if oral); and
5. Recording the required information, including the method of administration.

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

"Drug regimen review" means an individual resident record review conducted by the consultant pharmacist, including, but not limited to, laboratory tests, dietary requirements, physician's or advanced practice nurse's and nurse's clinical notes, physician's or advanced practice nurse's orders and progress notes, in order to monitor for potentially significant adverse drug reactions, drug-to-drug and drug-food interactions, allergies, contraindications, rationality of therapy, drug use evaluation, and laboratory test results.

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

"Facility" means a facility or distinct part of a facility licensed by the New Jersey State Department of Health and Senior Services as a long-term care facility.

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

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

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

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

"Licensed practical nurse" means an individual licensed by the New Jersey Board of Nursing pursuant to N.J.S.A. 45:11-27.

"Medication error" means a discrepancy between what the prescriber ordered and what the resident receives. The error may or may not be seen by the (pharmacist) surveyor during an observation of a resident receiving medication. If a medication error is seen by the surveyor during a medication observation pass, it shall be included in determining the medication error rate.

"Medication error rate" is calculated by the following equation: (number of errors observed divided by the opportunities for errors) x 100.

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

"Number of staff" means the number of registered professional nurses, licensed practical nurses and certified nurse aides who are scheduled to provide and be responsible for direct resident care on a particular shift, which is calculated by dividing the total actual hours worked by each category of staff member by the number of hours in the shift.

1. Actual hours worked includes the hours for each category of staff members included in this definition for which they will be providing direct resident care during any portion of the shift.

"Pharmacist" means an individual so licensed by the New Jersey State Board of Pharmacy, pursuant to N.J.A.C. 13:39-3.

"Physician" means a person licensed to practice medicine by the New Jersey State Board of Medical Examiners, pursuant to N.J.S.A. 45:9-1 et seq.

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

"Registered professional nurse" means an individual licensed by the New Jersey Board of Nursing pursuant to N.J.S.A. 45:11-26.

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

"Self administration" means a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a resident to himself or herself. The complete procedure of self-administration includes:

1. Removing an individual dose from a previously dispensed (in accordance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39), labeled container (including a unit dose container);
2. Verifying it with the directions on the label; and
3. Taking orally, injecting, inserting, or topically or otherwise administering the medication.

"Shift" means a standardized reporting period, which shall consist of, based on the facility's choice, either three eight-hour periods (day, evening and night) or two 12-hour periods (day and night).

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

"Staff-to-resident ratio" means a ratio calculated with the numerator being the number of staff for each category of direct resident care staff scheduled to work on a particular shift and the denominator being the number of residents in the facility during that particular shift.

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

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

## **HISTORY:**

Amended by R.2005 d.400, effective November 21, 2005.

See: 37 N.J.R. 1932(a), 37 N.J.R. 4437(a).

Added definition "Defibrillator".

Amended by R.2010 d.019, effective January 19, 2010.

See: 41 N.J.R. 42(a), 42 N.J.R. 468(b).

Added definitions "Actual hours worked", "Certified nurse aid", "Direct resident care", "Licensed practical nurse", "Number of staff", "Registered professional nurse", "Shift" and "Staff-to-resident ratio"; in definition "Commissioner", inserted "Commissioner of the" and ", or his or her designee" and substituted "Department" for "State Commissioner"; and in definition "Department", deleted "State" following "New Jersey".

## **CASE NOTES:**

Although pharmacy was not a "facility" as defined in a long term care facility regulation, N.J.A.C. 8:39-1.2, because the pharmacy acted as a long term care facility's mandatory pharmacy provider, N.J.A.C. 8:39-29.4(j) and 8:39-1.2 required the pharmacy to "observe, watch, or check" the long term care facility's crediting system; however, the obligation to monitor did not require the pharmacy to credit Medicaid for returned medications. *United States ex rel. Quinn v. Omnicare Inc.*, 382 F.3d 432, 2004 U.S. App. LEXIS 18474 (3d Cir. N.J. 2004).

**SUBCHAPTER 2. LICENSURE PROCEDURE****§ 8:39-2.1 Certificate of need**

- (a) According to the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H-1 et seq., and amendments thereto, a health care facility shall not be instituted, constructed, expanded, or licensed to operate except upon application for and receipt of a certificate of need issued by the Commissioner, in accordance with N.J.A.C. 8:33. Facilities exempt from certificate of need pursuant to law shall follow licensing procedures identified in N.J.A.C. 8:39-2.2.
- (b) Application forms for a certificate of need and instructions for completion may be obtained from:
- Office of Certificate of Need and Healthcare Facility Licensure  
Division of Healthcare Facilities Evaluation and Licensing  
New Jersey State Department of Health and Senior Services  
PO Box 358  
Trenton, NJ 08625-0358
- (c) The facility shall implement all conditions imposed by the Commissioner as specified in the certificate of need approval letter. Failure to implement the conditions may result in the imposition of sanctions in accordance with the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H-1 et seq., and amendments thereto.

**HISTORY:**

Amended by R.2007 d.83, effective March 19, 2007.

See: 38 N.J.R. 4141(a), 39 N.J.R. 924(a).

In (b), updated address.

**§ 8:39-2.2 Application for licensure**

- (a) Following acquisition of a certificate of need, or a determination that a certificate of need is not required, any person, organization, or corporation desiring to operate a facility shall make application to the Commissioner for a license on Appendix E, incorporated herein by reference which includes information regarding facility ownership, corporate officers and stockholders, and approval forms from local building, fire, health and zoning departments. A license application may be obtained from:

Office of Certificate of Need and Healthcare Facility Licensure  
Division of Healthcare Facilities Evaluation and Licensing  
New Jersey State Department of Health and Senior Services  
PO Box 358  
Trenton, NJ 08625-0358

- (b) The Department shall charge the following nonrefundable fees:

Annual licensure fee (new and renewal)	\$ 1,500 plus \$ 15.00 per bed
Add-a-bed	\$ 1,500 plus \$ 15.00 per additional bed
Hemodialysis provided by the LTC facility	\$ 1,125
Hemodialysis provided by a separate provider	\$ 750.00
Relocation of a facility (within the same county)	\$ 375.00



Transfer of ownership (includes initial licensure fee)	\$ 2,500 plus \$ 15.00 per bed
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Reduction in services or beds	\$ 250.00
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Neither the maximum annual licensure fee nor the fee for transfer of ownership for any single facility shall exceed \$ 4,000.

- (c) Any person, organization, or corporation considering application for license to operate a facility shall make an appointment for a preliminary conference at the Department with the Long-Term Care Licensing and Certification Program.
- (d) For all projects that are exempt from the certificate of need requirement, the Department shall evaluate the track record of the applicant in accordance with N.J.A.C. 8:33-4.10(e).
- (e) Any applicant denied a license to operate a facility shall have the right to a hearing in accordance with N.J.A.C. 8:33-4.10(e)4.

### HISTORY:

Amended by R.2004 d.160, effective April 19, 2004.

See: 35 N.J.R. 4838(a), 36 N.J.R. 1962(a).

In (b), increased fees throughout the table.

Amended by R.2007 d.83, effective March 19, 2007.

See: 38 N.J.R. 4141(a), 39 N.J.R. 924(a).

In (a), substituted "Appendix E, incorporated herein by reference" for "forms prescribed by the Department", "includes" for "include" and "A license application" for "Such forms", and updated address; and in (b), inserted table entry for "Reduction in services or beds".

### § 8:39-2.3 Newly constructed, expanded, or renovated facilities

Any construction, expansion, or renovation of a facility shall be completed in accordance with N.J.A.C. 8:39-31, Mandatory Physical Environment.

### § 8:39-2.4 Surveys and license

- (a) A license shall be issued to the operator of a facility when all of the following conditions are met:
  1. A completed licensure application and the appropriate fee have been submitted;
  2. An office conference for review of the conditions for licensure and operation has taken place between the Long-Term Care Licensing and Certification Program and representatives of the facility;
  3. The applicant has submitted the following documents to the Long-Term Care Licensing and Certification Program: a copy of the certificate of occupancy, and written approvals from the Health Care Plan Review Unit of the New Jersey Department of Community Affairs and the local health authority;
  4. Written approvals of the water supply and sewage disposal system from local officials are on file with the Department for any water supply or sewage disposal system not connected to an approved municipal system; and
  5. Survey(s) by representatives of the Department indicate that the facility meets the mandatory standards set forth in this chapter.
- (b) No facility shall begin to operate without prior approval from the Long-Term Care Licensing and Certification Program of the Department.

- (c) The facility shall accept no more than that number of residents for which it is approved and/or licensed.
- (d) Survey visits shall be made to a facility at any time by authorized staff of the Department. Such visits shall include, but shall not be limited to, the review of all facility documents and resident records and conferences with residents.
- (e) The license shall be granted for a period of one year, unless suspended or revoked, and shall be renewable annually on the original licensure date, or within 30 days thereafter, in accordance with the following:
  - 1. The facility shall receive a request for renewal fee as provided in N.J.A.C. 8:39-2.2(b), along with an application for a healthcare facility license renewal, Appendix F, incorporated herein by reference, 30 days prior to the expiration of the license. A renewal license shall not be issued unless the licensure fee and the renewal application is received by the Department; and
  - 2. The license shall not be renewed if local regulations, or any other requirements, which substantially affect the provision of services as required by this chapter, are not met.
- (f) The license shall be conspicuously posted in the facility.
- (g) The license shall not be assignable or transferable and shall be immediately void if the facility ceases to operate or if its ownership changes.
- (h) Any facility which was closed or substantially ceased operation of any of its beds, facilities, services, or equipment for any consecutive two-year period shall be required to obtain a certificate of need in accordance with N.J.A.C. 8:33-3.2 before renewing its license to operate such beds, facilities, services, or equipment.

**HISTORY:**

Amended by R.2007 d.83, effective March 19, 2007.

See: 38 N.J.R. 4141(a), 39 N.J.R. 924(a).

In (e)1, inserted "along with an application for a healthcare facility license renewal, Appendix F, incorporated herein by reference," and "and the renewal application".

**§ 8:39-2.5 Surrender of license**

The facility shall directly notify the Department, each resident, the resident's physician or advanced practice nurse, and any guarantors of payment concerned at least 30 days prior to the voluntary surrender of a license, or as directed under an order of revocation, refusal to renew, or suspension of licensure. In such cases, the license shall be returned to the Long-Term Care Licensing and Certification Program of the Department within seven calendar days from voluntary surrender, order of revocation, expiration, or suspension of license, whichever is applicable.

**§ 8:39-2.6 Waiver**

- (a) The Commissioner or his or her designee may, in accordance with the general purposes and intent of the Health Care Facilities Planning Act, P.L. 1971, c.136 and c.138, N.J.S.A. 26:2H-1 et seq., and amendments thereto, and the standards in this chapter, waive sections of this chapter if, in his or her opinion, such waiver would not endanger the life, safety, or health of the facility's residents or the public.
- (b) A facility seeking a waiver of the standards in this chapter shall apply in writing to the Director of the Long-Term Care Licensing and Certification Program of the Department.
- (c) A written application for waiver shall include at least the following:

1. The nature of the waiver requested;
  2. The specific standards for which a waiver is requested;
  3. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility or any individual upon full compliance;
  4. An alternative proposal which would ensure resident safety; and
  5. Documentation to support the application for waiver.
- (d) The Department reserves the right to request additional information before processing an application for waiver.
- (e) The Department shall issue to the facility written confirmation of either a grant or denial of any waiver request.

### **§ 8:39-2.7 Action against licensee**

Violations of this subchapter may result in action by the Department in accordance with N.J.A.C. 8:43E.

### **§ 8:39-2.8 Special long-term care services**

In accordance with N.J.A.C. 8:33H-1.6, the Department recognizes the following two special long-term care services, both of which require a certificate of need: behavioral management and ventilator care. Long-term care beds that are approved for these special services shall be designated separately on the facility's license.

### **§ 8:39-2.9 Chronic hemodialysis services**

- (a) If a facility provides hemodialysis services to its own long-term care residents only, the following conditions shall be met:
1. The facility shall be authorized to provide the service by the Long-Term Care Licensing and Certification Program of the Department subsequent to the submission and review of the information contained in this subchapter. The application shall describe how the standards in (a)2 through 4 below will be met. The facility shall comply with ambulatory care requirements for a chronic dialysis provider, in accordance with N.J.A.C. 8:43A-24, and the application shall describe how such compliance will be achieved. Waivers from the nine station minimum requirement at N.J.A.C. 8:43A-24.2 shall be considered on an individual basis;
  2. A consultant nephrologist who is Board Certified or Board eligible shall be designated and available to provide medical direction for the hemodialysis service;
  3. The facility shall identify the space where hemodialysis services will be provided:
    - i. Identified space shall be in compliance with the requirements at N.J.A.C. 8:43A-24, Licensure Standards for Ambulatory Care;
    - ii. If bedside hemodialysis services are offered, they shall be provided only in private rooms; and
  4. Hemodialysis shall be listed as a "service" on the facility's license.
- (b) If the facility or other separately licensed dialysis provider provides outpatient dialysis services on-site to persons who are not residents of the facility, the following conditions shall be met:

1. The facility shall file a licensing application in order to be authorized to provide the service. The facility shall comply with ambulatory care regulations for chronic dialysis services, in accordance with N.J.A.C. 8:43A, particularly N.J.A.C. 8:43A-24, and the application shall describe how such compliance will be achieved;
  2. Outpatient records shall be kept separately from inpatient records; and
  3. The hemodialysis program shall not utilize any space required by the long-term care program, such as passageways, corridors, or treatment room, and shall not require the commingling of hemodialysis patients with facility residents.
- (c) Hemodialysis services may be provided to residents of the long-term care facility by separately licensed dialysis providers under the following circumstances:
1. The dialysis provider shall file a licensing application in order to be authorized to provide the service. The facility shall comply with ambulatory care requirements for chronic dialysis services, in accordance with N.J.A.C. 8:43A, particularly N.J.A.C. 8:43A-24, and the application shall describe how such compliance will be achieved;
  2. The provider shall demonstrate the ability to serve nine patients Statewide within six months of licensing approval;
  3. The provider shall have a New Jersey office or execute a jurisdictional agreement with the Department;
  4. The provider shall describe all staffing, and how staffing will be provided at multiple sites, if applicable;
  5. A copy of the contract between the dialysis provider and the long-term care facility shall be included with the licensing application. The contract shall clearly state the roles and responsibilities of both the dialysis provider and the long-term care facility. Any change in dialysis provider shall require prior authorization and submission of a separate licensure application by the dialysis provider;
  6. The Department shall charge a fee for licensure of the dialysis service as an ambulatory care facility in accordance with N.J.A.C. 8:43A-2.2(b). Each site of service provision shall be considered a satellite. The Department shall charge a biennial inspection fee in accordance with N.J.A.C. 8:43A-2.2(m);
  7. Hemodialysis shall be listed as a "service" on the facility's license; and
  8. Both the provider and the long-term care facility shall inform the Department in writing 30 days prior to any planned service interruption and shall include a plan for the continuing care of any dialysis patients.
- (d) Any long-term care facility which proposes to offer hemodialysis services through a separately licensed dialysis provider shall also comply with the following requirements:
1. The facility shall request written authorization from the Long-Term Care Licensing and Certification Program to contract with a licensed outside provider prior to implementing the service. A copy of the contract between the dialysis provider and the long-term care facility shall be included with the licensing application. The contract shall clearly state the roles and responsibilities of both the dialysis provider and the long-term care facility. Any change in dialysis provider shall require prior authorization and submission of a separate licensure application by the new dialysis provider; and
  2. The facility shall identify the space in which the service will be provided, including documentation that the space meets the requirements of N.J.A.C. 8:43A-24. Any

renovations or construction shall receive prior approval from the Department. Space required by the long-term care facility programs shall not be used.

### § 8:39-2.10 Peritoneal dialysis

- (a) If a long-term care facility offers peritoneal renal dialysis services to its own residents only, the following conditions shall be met:
1. A licensing application shall not be required;
  2. The facility shall forward to the Department an attestation that the information listed below is available at the facility for review. Following receipt of this attestation, authorization to provide the service may be granted:
    - i. Policies and procedures for service provision, which shall include the following:
      - (1) Staff qualifications and training;
      - (2) Admission criteria;
      - (3) Transfer agreement with a certified ESRD hospital facility;
      - (4) Quality assurance mechanisms and criteria;
      - (5) Infection prevention and control, including bag disposal;
      - (6) Emergency situations;
      - (7) Dietary requirements; and
      - (8) How and where any necessary laboratory work will be completed;
  3. A consultant nephrologist shall be designated and available to provide medical direction for the service; and
  4. Peritoneal dialysis shall be listed as a "service" on the facility's license.
- (b) Separately licensed dialysis providers may offer peritoneal dialysis services in a long-term care facility under the following circumstances:
1. All requirements in (a) above shall be met;
  2. The dialysis provider shall be licensed as specified at N.J.A.C. 8:39-2.9(c);
  3. A copy of the contract agreement for service provision between the dialysis provider and the long-term care facility shall be reviewed and approved by the Long-Term Care Licensing and Certification Program of the Department prior to the authorization of the long-term care facility to provide the service through a separately licensed agency. The agreement shall clearly state the roles and responsibilities of both parties; and
  4. Both the long-term care facility and the dialysis agency shall notify the Department in writing 30 days prior to any planned service interruption and shall include a plan for the continuing care of any dialysis patients.

### § 8:39-2.11 Add-a-bed

- (a) Pursuant to N.J.S.A. 26:2H-7.2, a facility may request approval from the Department to increase total licensed beds by no more than 10 beds or 10 percent of its licensed bed capacity, whichever is less, without certificate of need approval. No more than one such request for approval shall be submitted every five years.
- (b) The Department shall charge a nonrefundable fee of \$ 1,500 plus \$ 15.00 per additional bed for the filing of an application to add beds to increase a facility's total licensed capacity. Applicants shall contact the Office of Certificate of Need and Healthcare Facility Licensure at (609) 633-9042 to obtain Add-a-bed application forms.

The completed forms, along with scaled floor plans and the appropriate fee, must be forwarded to the Department at the following address:

Office of Certificate of Need and Healthcare Facility Licensure  
Division of Healthcare Facilities Evaluation and Licensing  
New Jersey Department of Health and Senior Services  
PO Box 358  
Trenton, New Jersey 08625-0358

- (c) The Department shall deny an add-a-bed application if any of the following conditions exist:
1. The facility's track record is unsatisfactory, in accordance with N.J.A.C. 8:33-4.10 and 8:43E-5.1;
  2. The applicant fails to demonstrate that the facility has sufficient space to implement the new licensed bed capacity in a manner meeting Federal construction standards contained in the 1996-97 edition of "Guidelines For Design and Construction of Hospital and Health Care Facilities" (American Institute of Architects Academy of Architecture for Health, with assistance from the U.S. Department of Health and Human Services. The American Institute of Architects Press: Washington, DC), incorporated herein by reference as amended and supplemented;
  3. The applicant fails to demonstrate that the facility has provided sufficient nurse staffing hours, in accordance with this chapter, to meet the needs of the current resident census;
  4. The addition of beds will result in a unit size in excess of 64 beds;
  5. The addition of beds will result in a violation of State licensure or Federal certification requirements; or
  6. The proposed additional beds will result in a room occupancy that exceeds two residents per room.

#### **HISTORY:**

Amended by R.2004 d.160, effective April 19, 2004.

See: 35 N.J.R. 4838(a), 36 N.J.R. 1962(a).

In (b), substituted "\$ 1,500" for "\$ 1,000" and "\$ 15.00" for "\$ 10.00".

Amended by R.2007 d.83, effective March 19, 2007.

See: 38 N.J.R. 4141(a), 39 N.J.R. 924(a).

In (b), substituted "Office of Certificate of Need and Healthcare Facility Licensure" for "Long Term Care Licensing and Certification Program", and updated address.

#### **§ 8:39-2.12 Transfer of ownership**

- (a) In accordance with N.J.A.C. 8:33-3.3(a)4, the transfer of ownership of a long-term care facility shall not require a certificate of need except when the proposed owner does not satisfy the Department's track record review.
- (b) Prior to transferring ownership of a facility, the prospective new owner shall submit an application to the Long Term Care Licensing and Certification Program. The application shall include the following items:
1. The transfer of ownership fee of \$ 2,500 plus \$ 15.00 per bed, in accordance with N.J.A.C. 8:39-2.2(b);

2. A cover letter stating the applicant's intent to purchase the facility, and identification of the facility by name, address, county, and number and type of licensed beds;
  3. A description of the proposed transaction, including:
    - i. Identification of the current owners of the facility;
    - ii. Identification of 100 percent of the proposed new owners, including the names and addresses of all principals (that is, individuals and/or entities with a 10 percent or more interest); and
    - iii. If applicable, a copy of an organizational chart, including parent corporations and wholly owned subsidiaries;
  4. A copy of the agreement of sale and, if applicable, a copy of any lease and/or management agreements; and
  5. Disclosure of any licensed health care facilities owned, operated, or managed by the proposed owner or any of the principals, in New Jersey or any other state. If facilities are owned, operated, or managed in other states, letters from the regulatory agencies in each respective state, verifying that the facilities have operated in substantial compliance during the last 12 month period and have had no enforcement actions imposed during that period of time, shall be included in the application.
- (c) Approval of a transfer of ownership is contingent upon a review of the applicant's track record, in accordance with N.J.A.C. 8:33-4.10 and 8:43E-5.1.
- (d) Approval of a transfer of ownership is contingent upon payment of all outstanding Medicaid audit claims and State penalties issued by the Department against the current owner, or written verification by the applicant that the applicant will assume responsibility for payment of such audit findings and State penalties.
- (e) When a transfer of ownership application has been reviewed and deemed acceptable, an approval letter from the Long-Term Care Licensing and Certification Program shall be sent to the applicant along with licensure application forms.
- (f) Within five days after the transaction has been completed, the applicant shall submit the following documents to the Long-Term Care Licensing and Certification Program:
1. Completed licensure application forms;
  2. A notarized letter stating the date on which the transaction occurred; and
  3. A copy of a certificate of continuing occupancy from the local township, or a letter from the township verifying a policy of not issuing any such document for changes of ownership.
- (g) For Medicaid certification, the new owner shall contact the Long-Term Care Licensing and Certification Program at (609) 633-9042.
- (h) For Medicare certification, the new owner shall contact the Assistant Director of Long-Term Care Assessment and Survey at (609) 633-8981.

**HISTORY:**

Amended by R.2004 d.160, effective April 19, 2004.

See: 35 N.J.R. 4838(a), 36 N.J.R. 1962(a).

In (b), substituted "\$ 2,500" for "\$ 2,000" and "\$ 15.00" for "\$ 10.00" in 1.

SUBCHAPTER 3. COMPLIANCE WITH MANDATORY RULES AND ADVISORY STANDARDS

### **SUBCHAPTER 3. COMPLIANCE WITH MANDATORY RULES AND ADVISORY STANDARDS**

#### **§ 8:39-3.1 Mandatory rules**

- (a) Mandatory rules contain minimum and essential requirements of care provided by a facility.
- (b) Failure to comply with any mandatory rules contained in this chapter shall constitute a deficiency for which the Department may take any or all of the enforcement actions set forth in N.J.A.C. 8:43E.

#### **§ 8:39-3.2 Advisory standards**

- (a) Advisory standards contain benchmarks of excellence or superior attainment in providing care of high quality.
- (b) Facilities are strongly encouraged to use advisory standards in striving to provide the highest quality of care possible.
- (c) Failure to comply with any or all advisory standards shall not constitute a deficiency or result directly or indirectly in any enforcement action by the Department.
- (d) Compliance with advisory standards shall not be used as an indication of whether the facility is in compliance with mandatory rules or whether a facility should be made subject to a penalty or other action to protect residents.

#### **§ 8:39-3.3 Reporting compliance with advisory standards**

- (a) Compliance with advisory standards shall be calculated in accordance with the following:
  - 1. The Department shall verify that at least 90 percent of no more than 30 advisory standards randomly selected from the total number of advisory standards which the facility claims to have met are in fact met; and
  - 2. If the compliance rate determined at (a)1 above is 90 percent or greater, then, for any advisory subchapter in which the facility has claimed to meet 65 percent or more of the standards in the subchapter, recognition for meeting the entire subchapter shall be given.
- (b) If a facility applies for a certificate of need, compliance with six or more of the following advisory subchapters at the time of the most recent survey of the facility shall be taken into consideration: access to care (N.J.A.C. 8:39-6), resident assessment and care plans (N.J.A.C. 8:39-12), pharmacy (N.J.A.C. 8:39-30), infection control and sanitation (N.J.A.C. 8:39-20), resident activities (N.J.A.C. 8:39-8), dietary services (N.J.A.C. 8:39-18), medical services (N.J.A.C. 8:39-24), nurse staffing (N.J.A.C. 8:39-26), physical environment (N.J.A.C. 8:39-32), and quality assessment and/or quality improvement (N.J.A.C. 8:39-34).
- (c) If a facility can demonstrate that it has a system in place to meet the requirement, even though it is not applicable at the time of the survey, the surveyors may deem that, in their judgment, the standard is met.

### **SUBCHAPTER 4. MANDATORY RESIDENT RIGHTS**

#### **§ 8:39-4.1 Resident rights**

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



1. To retain the services of a physician or advanced practice nurse the resident chooses, at the resident's own expense or through a health care plan;
2. To have a physician or advanced practice nurse explain to the resident, in language that the resident understands, his or her complete medical condition, the recommended treatment, and the expected results of the treatment, except when the physician deems it medically inadvisable to give such information to the resident and records the reason for such decision in the resident's medical record; and provides an explanation to his or her next of kin or guardian;
3. To participate, to the fullest extent that the resident is able, in planning his or her own medical treatment and care;
4. To refuse medication and treatment after the resident has been informed, in language that the resident understands, of the possible consequences of this decision. The resident may also refuse to participate in experimental research, including the investigations of new drugs and medical devices. The resident shall be included in experimental research only when he or she gives informed, written consent to such participation;
5. To be free from physical and mental abuse and/or neglect;
6. To be free from chemical and physical restraints, unless they are authorized by a physician or advanced practice nurse for a limited period of time to protect the resident or others from injury. Under no circumstances shall the resident be confined in a locked room or restrained for punishment, for the convenience of the nursing home staff, or with the use of excessive drug dosages;
7. To manage his or her own finances or to have that responsibility delegated to a family member, an assigned guardian, the nursing home administrator, or some other individual with power of attorney. The resident's authorization must be in writing, and must be witnessed in writing;
8. To receive a written statement or admission agreement describing the services provided by the nursing home and the related charges. Such statement or admission agreement must be in compliance with all applicable State and Federal laws. This statement or agreement must also include the nursing home's policies for payment of fees, deposits, and refunds. The resident shall receive this statement or agreement prior to or at the time of admission, and afterward whenever there are any changes;
9. To receive a quarterly written account of all resident's funds and itemized property that are deposited with the facility for the resident's use and safekeeping and of all financial transactions with the resident, next of kin, or guardian. This record shall also show the amount of property in the account at the beginning and end of the accounting period, as well as a list of all deposits and withdrawals, substantiated by receipts given to the resident or his or her guardian;
10. To have daily access during specified hours to the money and property that the resident has deposited with the nursing home. The resident also may delegate, in writing, this right of access to his or her representative;
11. To live in safe, decent, and clean conditions in a nursing home that does not admit more residents than it can safely accommodate while providing adequate nursing care;
12. To be treated with courtesy, consideration, and respect for the resident's dignity and individuality;

13. To receive notice of an intended transfer from one room to another within the facility or a change in roommate, including a right to an informal hearing with the administrator prior to the transfer as well as a written statement of the reasons for such transfer. The nursing home shall not move the resident to a different bed or room in the facility if the relocation is arbitrary and capricious. A transfer would not be considered arbitrary and capricious if a facility can document a clinical necessity for relocating the resident, such as a need for isolation or to address behavior management problems, or there is a hardship to an applicant for admission through a delay caused by inefficient distribution of beds by gender;
14. To wear his or her own clothes, unless this would be unsafe or impractical. All clothes provided by the nursing home shall fit in a way that is not demeaning to the resident;
15. To keep and use his or her personal property, unless this would be unsafe, impractical, or an infringement on the rights of other residents. The nursing home shall take precautions to ensure that the resident's personal possessions are secure from theft, loss, and misplacement;
16. To have physical privacy. The resident shall be allowed, for example, to maintain the privacy of his or her body during medical treatment and personal hygiene activities, such as bathing and using the toilet, unless the resident needs assistance for his or her own safety;
17. To have reasonable opportunities for private and intimate physical and social interaction with other people, including arrangements for privacy when the resident's spouse visits. If the resident and his or her spouse are both residents of the same nursing home, they shall be given the opportunity to share a room, unless this is medically inadvisable, as documented in their records by a physician or advanced practice nurse;
18. To confidential treatment of information about the resident. Information in the resident's records shall not be released to anyone outside the nursing home without the resident's approval, unless the resident transfers to another health care facility, or unless the release of the information is required by law, a third-party payment contract, or the New Jersey State Department of Health and Senior Services;
19. To receive and send mail in unopened envelopes, unless the resident requests otherwise. The resident also has a right to request and receive assistance in reading and writing correspondence unless it is medically contraindicated, and documented in the record by a physician or advanced practice nurse;
20. To have unaccompanied access to a telephone at a reasonable hour to conduct private conversations, and, if technically feasible, to have a private telephone in his or her living quarters at the resident's own expense;
21. To stay out of bed as long as the resident desires and to be awakened for routine daily care no more than two hours before breakfast is served, unless a physician recommends otherwise and specifies the reasons in the resident's medical record;
22. To receive assistance in awakening, getting dressed, and participating in the facility's activities, unless a physician or advanced practice nurse specifies reasons in the resident's medical record;
23. To meet with any visitors of the resident's choice between 8:00 A.M. and 8:00 P.M. daily. If the resident is critically ill, he or she may receive visits at any time from next of kin or a guardian, unless a physician or advanced practice nurse documents that this would be harmful to the resident's health;

24. To take part in nursing home activities, and to meet with and participate in the activities of any social, religious, and community groups, as long as these activities do not disrupt the lives of other residents;
25. To leave the nursing home during the day with the approval of a physician or advanced practice nurse and with the resident's whereabouts noted on a sign-out record. Arrangements may also be made with the nursing home for an absence overnight or longer;
26. To refuse to perform services for the nursing home;
27. To request visits at any time by representatives of the religion of the resident's choice and, upon the resident's request, to attend outside religious services at his or her own expense. No religious beliefs or practices shall be imposed on any resident;
28. To participate in meals, recreation, and social activities without being subjected to discrimination based on age, race, religion, sex, nationality, or disability. The resident's participation may be restricted or prohibited only upon the written recommendation of his or her physician or advanced practice nurse;
29. To organize and participate in a resident council that presents residents' concerns to the administrator of the facility. A resident's family has the right to meet in the facility with the families of other residents in the facility;
30. To discharge himself or herself from the nursing home by presenting a release signed by the resident. If the resident is an adjudicated mental incompetent, the release must be signed by his or her next of kin or guardian;
31. To be transferred or discharged more of the following reasons, with the reason for the transfer or discharge recorded in the resident's medical record:
  - i. In an emergency, with notification of the resident's physician or advanced practice nurse and next of kin or guardian;
  - ii. For medical reasons or to protect the resident's welfare or the welfare of others;
  - iii. To comply with clearly expressed and documented resident choice, or in conformance with the New Jersey Advance Directives for Health Care Act, as specified in N.J.A.C. 8:39-9.6(d); or
  - iv. For nonpayment of fees, in situations not prohibited by law;
32. To receive written notice at least 30 days in advance when the nursing home requests the resident's transfer or discharge, except in an emergency. Written notice shall include the name, address, and telephone number of the New Jersey Office of the Ombudsman for the Institutionalized Elderly, and shall also be provided to the resident's next of kin or guardian 30 days in advance;
33. To be given a written statement of all resident rights as well as any additional regulations established by the nursing home involving resident rights and responsibilities. The nursing home shall require each resident or his or her guardian to sign a copy of this document. In addition, a copy shall be posted in a conspicuous, public place in the nursing home. Copies shall also be given to the resident's next of kin and distributed to staff members. The nursing home is responsible for developing and implementing policies to protect resident rights;
34. To retain and exercise all the constitutional, civil, and legal rights to which the resident is entitled by law. The nursing home shall encourage and help each resident to exercise these rights; and

35. To voice complaints without being threatened or punished. Each resident is entitled to complain and present his or her grievances to the nursing home administrator and staff, to government agencies, and to anyone else without fear of interference, discharge, or reprisal. The nursing home shall provide each resident and his or her next of kin or guardian with the names, addresses, and telephone numbers of the government agencies to which a resident can complain and ask questions, including the Department and the Office of the Ombudsman for the Institutionalized Elderly. These names, addresses, and telephone numbers shall also be posted in a conspicuous place near every public telephone and on all public bulletin boards in the nursing home.
- (b) Each resident, resident's next of kin, and resident's guardian shall be informed of the resident rights enumerated in this subchapter, and each shall be explained to him or her. None of these rights shall be abridged or violated by the facility or any of its staff.

## SUBCHAPTER 5. MANDATORY ACCESS TO CARE

### § 8:39-5.1 Mandatory policies and procedures for access to care

- (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.
- (b) There shall be no discrimination against any resident or group of residents based on method of payment.
- (c) The facility shall meet all currently applicable conditions attached to any certificate of need that has been granted to it.
- (d) If a facility has reason to believe, based on a resident's behavior, that the resident poses a danger to himself or herself or others, and that the facility is not capable of providing proper care to the resident, then an evaluation should be performed and documented in accordance with the Guidelines for Inappropriate Behavior and Resident to Resident Abuse in Appendix B, incorporated herein by reference.
- (e) The facility shall make available to indigent individuals at least five percent of its beds or, if the facility is licensed for 100 or more beds, at least 10 percent of its beds. For purposes of this section, an individual is "indigent" if he or she is an applicant for admission or a current resident of the facility, and if he or she would otherwise meet the eligibility requirements of Medicaid reimbursement or county or municipal financial assistance for nursing home care.

### CASE NOTES

Former N.J.A.C. 8:30-14.4(a), which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J.S.A. 26:2H-5, 26:2H-8, and 26:2H-12, did not exceed the power given to the State under N.J.S.A. 26:2H-1 et seq.; the argument that the State was attempting to regulate the quantity of health care services, rather than the quality of health care services was rejected because the acute shortage of nursing home beds for indigent persons was a public health concern, and the regulations were not arbitrary or unreasonable. In re Health Care Admin. Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (1980), writ of certiorari denied by 449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668, 49 U.S.L.W. 3331 (1980).

Former N.J.A.C. 8:30-14.4(a), which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J.S.A. 26:2H-5, did not constitute a taking without just compensation under N.J. Const. art. I, para. 20 because the regulation served a valid public purpose and the nursing home was given a right to administrative and judicial review of any allotment of beds. In re Health Care Admin. Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (1980), writ of certiorari denied by 449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668, 49 U.S.L.W. 3331 (1980).

Former N.J.A.C. 8:30-14.4(a), which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J.S.A. 26:2H-5, did not violate the equal protection rights of private facilities because the private facilities were involved in a quasi-public activity and were therefore subject to extensive regulation in the public interest; the classification was not suspect and did not implicate a fundamental right and the nursing home's obligation to serve the public interest was rationally related to the regulations. In re Health Care Admin. Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (1980), writ of certiorari denied by 449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668, 49 U.S.L.W. 3331 (1980).

Former N.J.A.C. 8:30-14.4(a), which required nursing homes to make available "a reasonable number of their beds to indigent persons" as a condition of licensure under N.J.S.A. 26:2H-5, did not conflict with the federal Medicaid statute, 42 U.S.C. § 1396 et seq.; there was no factual evidence presented to support the claim that the reimbursement rates set in the program violated the federal rates or that compelled participation in the state program violated the voluntary nature of the federal program, constituting an unjust taking, because there was no requirement in the regulations that a facility seek reimbursement from Medicaid. In re Health Care Admin. Board, 83 N.J. 67, 415 A.2d 1147, 1980 N.J. LEXIS 1365 (1980), writ of certiorari denied by 449 U.S. 944, 101 S. Ct. 342, 66 L. Ed. 2d 208, 1980 U.S. LEXIS 3668, 49 U.S.L.W. 3331 (1980).

### § 8:39-5.2 Admissions

- (a) The facility shall establish a single waiting list in chronological order. The order of names shall be predicated upon the order in which a completed written application is received. Hospitalized individuals ready for readmission to the facility are to be added to the top of the list as soon as the hospital notifies the facility of the contemplated discharge. As soon as a bed becomes available, it shall be filled from this waiting list. Provisions can be made for emergency, life-threatening situations or life-care community admissions.
1. The facility shall meet the following requirements:
    - i. The facility shall maintain only one waiting list; this list shall reflect a roster updated on a regular basis, of all individuals who have applied for admission to the facility;
    - ii. The waiting list shall reflect in chronological order the full name and address of the individual applying by the date the written application for admission is made;
    - iii. Facilities that participate in the Medicaid program shall utilize the waiting list to admit individuals on a first-come, first-serve basis in the order in which they apply until the provider's Medicaid occupancy level equals the Statewide occupancy level, or the Medicaid occupancy level set forth in the provider's Certificate of Need, whichever is higher; and
    - iv. A file shall be maintained containing full documentation to support any valid reason why the individual whose name appears first on the waiting list is not admitted to the facility.
  2. Any Medicaid participating facility whose Medicaid occupancy level is less than the Statewide occupancy level shall not deny admission to a Medicaid eligible individual who has been authorized for nursing facility services by the Long-Term Care Field Office when a bed becomes available in accord with the waiting list.
    - i. Under the provisions of N.J.S.A 10:5-12.2, a facility with a residential unit or a life-care community may give its own residents priority when a bed becomes available.
- (b) The facility shall not deny admission to any applicant for admission ("applicant for admission" means an individual who has made a formal application) based on diagnosis or health care needs if the applicant's health care needs can be reasonably

accommodated without reducing the quality of care provided to other residents, and are commensurate with the services provided by the facility.

- (c) Whenever the facility denies admission to an applicant for admission, the facility, within 14 days of the denial, shall provide written notice of the denial and the reasons therefore, to the applicant or person applying on the applicant's behalf. A record of each completed application, including the disposition and stated reason if admission is denied, shall be kept for one year.

### **§ 8:39-5.3 Transfers**

- (a) The facility shall arrange for transfer of residents to other health care facilities, and to health care services provided outside the nursing home, and in accordance with the physician's or advanced practice nurse's orders.
- (b) All transfers shall be in accordance with N.J.A.C. 8:39-4.1.

#### **HISTORY:**

Amended by R.2011 d.198, effective August 1, 2011 (operative October 30, 2011).

See: 42 N.J.R. 1462(a), 43 N.J.R. 1875(a).

Deleted former (a); and recodified former (b) and (c) as (a) and (b).

### **§ 8:39-5.4 Discharges**

- (a) No resident shall be discharged between 5:00 P.M. and 8:00 A.M., except in an emergency or with the consent of the resident and family or responsible person.
- (b) Discharge plans, for those residents considered to be likely candidates for discharge into the community or a less intensive care setting, shall be developed by the interdisciplinary team prior to discharge and shall reflect communication with the resident and/or the resident's family.
- (c) All discharges shall be in accordance with N.J.A.C. 8:39-4.1 and 39.

## **SUBCHAPTER 6. ADVISORY ACCESS TO CARE**

### **§ 8:39-6.1 Advisory admission policies and procedures**

- (a) The waiting list of the facility incorporates a system to contact applicants or families at least quarterly, or according to an alternate schedule approved by the Department, to advise them concerning the status of the application and to inquire of the applicant's interest in remaining on the waiting list.
- (b) Before admission, the resident's physician, the facility's social worker, the facility's admissions officer (if different from the social worker), and a registered professional nurse discuss the appropriateness of the placement.
- (c) The facility makes available to indigent individuals at least 10 percent of its beds or, if the facility is licensed for 100 or more beds, at least 15 percent of its beds. For purposes of this subsection, an individual is "indigent" if he or she is an applicant for admission or a current resident of the facility, and if he or she would otherwise meet the eligibility requirements of Medicaid reimbursement or county or municipal financial assistance for nursing home care.
- (d) The facility provides a copy of admissions policies and criteria to all applicants for admission.

**SUBCHAPTER 7. MANDATORY RESIDENT ACTIVITIES****§ 8:39-7.1 Mandatory administrative organization for resident activities**

- (a) The director of resident activities shall supervise all resident activity staff and coordinate all resident activity programs.
- (b) The director of resident activities shall hold at least one of the following four qualifications:
  - 1. A baccalaureate degree from an accredited college or university with a major area of concentration in recreation, creative arts therapy, therapeutic recreation, art, art education, psychology, sociology, or occupational therapy;
  - 2. A high school diploma and three years of experience in resident activities in a health care facility and satisfactory completion of an activities education program approved by the Department, after a review of the specific curriculum, consisting of 90 hours of training, and incorporating the following elements:
    - i. Overview of the activity profession;
    - ii. Human development: the late adult years;
    - iii. Standards of practice: practitioner behavior;
    - iv. Activity care planning for quality of life; and
    - v. Methods of service delivery in the activity profession;
  - 3. Served as director of resident activities on June 20, 1988, and has continuously served as activities director since that time; or
  - 4. Holds current certification from the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, P.O. Box 62589, Virginia Beach, Virginia 23466-2589) or the National Council for Therapeutic Recreation Certification (National Council for Therapeutic Recreation, Inc., P.O. Box 479, Thiells, NY 10984-0479).
- (c) Activities directors who are employed in that capacity as of August 20, 2001, and who have completed an activities education course which was previously approved by the Department, shall not be required to complete the course described at (b)2 above.

**§ 8:39-7.2 Mandatory staffing amounts and availability for activities**

An average of 45 minutes of resident activities staff time per resident per week shall be devoted to resident activities, which requires at least one full-time equivalent staff member for every 53 residents.

**§ 8:39-7.3 Mandatory resident activity services**

- (a) Resident activities staff shall arrange a diversity of programs to maintain residents' sense of usefulness and self-respect. Included shall be activities in each of the following categories:
  - 1. Social (for example, parties, club meetings, picnics, and other special events);
  - 2. Physical (for example, exercise, sports, dancing, and swimming);
  - 3. Creative (for example, crafts, poetry, drama, music therapy, art therapy, and gardening);

4. Educational and cultural (for example, discussion groups, guest speaker programs, concerts and other forms of live entertainment, and international meals);
  5. Spiritual, such as religious services;
  6. Awareness, including cognitive and sensory individual and group stimulation for confused and disoriented residents; and
  7. Community-integrating (for example, visits by community volunteers, visits by nursery school classes, exchange visits with other health care facilities, participation in senior citizen organization meetings or support group sessions, and participation in adopt-a-grandparent programs).
- (b) If the facility requires an exception from any of the categories of activities listed at (a)1 through 7 above, reasons for the exception, such as impracticability or lack of appropriateness or interest on the part of residents, shall be documented and written documentation of the reasons for the exception shall be provided to the Department upon request.
- (c) Resident activity programs shall take place in individual, small group, and large group settings.
- (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement.
- (e) Residents may participate in the activities program regardless of their financial status, with the exception of special events for which there is a charge for all residents.
- (f) At least weekly, a listing of all scheduled activities shall be posted in a conspicuous place in the facility.
- (g) Resident activities programs shall be developed and modified on the basis of input from residents, as well as staff, family, and others.

#### **§ 8:39-7.4 Mandatory space and environment for resident activities**

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

### **SUBCHAPTER 8. ADVISORY RESIDENT ACTIVITIES**

#### **§ 8:39-8.1 Advisory policies and procedures for resident activities**

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

#### **§ 8:39-8.2 Advisory staff qualifications for resident activities**

The director of resident activities possesses a baccalaureate degree from an accredited college or university with a major area of concentration in therapeutic recreation or creative arts therapy or holds current certification from the National Certification Council for Activity Professionals (National Certification Council for Activity Professionals, P.O. Box 62589, Virginia Beach, Virginia 23466-2589) or National Council for Therapeutic Recreation Certification (National Council for Therapeutic Recreation, Inc., P.O. Box 479, Thiells, NY 10984-0479).



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

- (a) At least 55 minutes of resident activities staff time per resident per week is devoted to resident activities. (This is an average. It is equal to one full-time equivalent staff member for every 44 residents.)
- (b) The facility maintains an active volunteer program that includes scheduled visits to the facility on at least a weekly basis.

**§ 8:39-8.4 Advisory resident services for resident activities**

- (a) Resident activity programs are conducted during at least four evenings per week.
- (b) Field trips are accessible for all residents who choose to participate, unless their participation would not be clinically feasible.
- (c) Regularly scheduled outdoor recreation is provided.
- (d) There is a pet therapy program for interested residents, with safeguards to prevent interference in the lives of other residents, and the program complies with policies and procedures developed by the facility (See Appendix A for example).
- (e) The facility has an organized program for visits to residents by school or pre-school children throughout the year.

**SUBCHAPTER 9. MANDATORY ADMINISTRATION****§ 8:39-9.1 Ownership**

- (a) The facility shall inform the Department of the ownership and management of the facility and its location, and proof of ownership shall be available at the facility.
  1. In the case of group or corporate management of a facility, the facility shall specify:
    - i. The name and address of the firm or corporation; and
    - ii. The names and addresses of all stockholders who own 10 percent or greater of the voting shares; members of any limited liability corporation; partners; and directors of the firm or corporation.
  2. Any proposed change in ownership shall be approved by the Department in accordance with N.J.A.C. 8:39-2.12.
- (b) The facility shall not be owned or operated by any person convicted of a crime relating adversely to the person's capability of owning or operating the facility.

**§ 8:39-9.2 Administrator**

- (a) The facility shall be directed by an individual who holds a current New Jersey license as a nursing home administrator. The administrator shall be administratively responsible for all aspects of the facility.
  1. In a facility with more than 240 beds, in addition to the licensed administrator, there shall be a full-time administrative supervisor who is assigned the evening shift and reports directly to the licensed administrator.
  2. In a facility with 100 beds or more, the administrator shall serve full-time in an administrative capacity within the facility.

3. In facilities with fewer than 100 beds, a licensed administrator shall serve at least half-time within the facility.
  4. Two facilities may share a common administrator, if such facilities are within a 20-mile radius and if the total number of beds for which both facilities are licensed is no more than 120.
- (b) A facility shall not retain in any administrative, managerial, supervisory, or similar position, a nursing home administrator whose license is either suspended or revoked, pursuant to N.J.S.A. 26:2H-27 and 26:2H-28 and N.J.A.C. 8:34-1.1.
- (c) When a vacancy exists in the position of administrator for 48 hours or more, the facility shall arrange for licensed administrative supervision on a consultant basis, which shall continue until a new licensed administrator shall be appointed, which shall be within 90 days of the appointment of the consultant.

### § 8:39-9.3 Mandatory policies and procedures for staff

- (a) There shall be written policies and procedures for personnel that are reviewed annually, revised as needed, and implemented. They shall include at least:
1. A written job description for each category of personnel in the facility and distribution of a copy to each newly hired employee;
  2. Personnel policies in compliance with Federal and State requirements;
  3. A system to ensure that written, job-relevant criteria are used in making evaluation, hiring, and promotion decisions;
  4. A system to ensure that employees meet ongoing requirements for credentials; and
  5. Written criteria for personnel actions that require disciplinary action.
- (b) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental health, emotionally stable, of good moral character, and concerned for the safety and well-being of residents, and have not been convicted of a crime relating adversely to the person's ability to provide care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.)
- (c) The facility shall ensure that all private duty nursing staff and contract personnel are monitored and those who do not meet the requirements at (b) above or facility policies and procedures are not permitted to perform services in the facility.
- (d) The facility shall develop and implement a grievance procedure for all staff. The procedure shall include, at least, a system for receiving grievances, a specified response time, assurance that grievances are referred appropriately for review, development of resolutions, and follow-up action.
- (e) Each staff member shall wear clean clothes and shall use good personal hygiene.

### § 8:39-9.4 Mandatory notification

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

- (b) Results of the most recent licensure survey, Federal standard certification conducted by the Department and any plan of correction shall be available for inspection by any resident or visitor, in a readily accessible place, at all times. A notice announcing the availability of those results and all other surveys conducted in the past 12 months shall be conspicuously posted in diverse readily accessible areas of the facility.
- (c) The facility shall make all policy and procedure manuals available to residents, families, and guardians during normal business hours or by prior arrangement.
- (d) A facility shall notify the Department immediately in writing at such time as it becomes financially insolvent and upon the filing of a voluntary or involuntary petition for bankruptcy under Title 11 of the United States Code.
- (e) The facility shall notify the Department immediately by telephone at (609) 633-8981 or (800) 792-9770 after business hours, followed within 72 hours by written confirmation, of the termination of employment of the administrator or the director of nursing, and the name and qualifications of the proposed replacement.
- (f) The facility shall notify the State Office of the Ombudsman for the Institutionalized Elderly at (800) 792-8820 immediately of any suspected or reported resident abuse, neglect, or exploitation of residents aged 60 or older, pursuant to P.L. 1983 c. 43, N.J.S.A. 52:27G-7.1, and shall notify the Department immediately at the telephone numbers indicated in (e) above with respect to residents under the age of 60.
- (g) The facility shall notify the Department of the admission of any resident under 18 years of age.

**HISTORY:**

Amended by R.2008 d.52, effective March 3, 2008.

See: 39 N.J.R. 314(a), 40 N.J.R. 1094(a).

Rewrote (e); recodified former (e)3i as new (f); rewrote (f); and recodified former (f) as (g).

**§ 8:39-9.5 Mandatory policies and procedures for residents' accounts**

- (a) The facility shall maintain a written record of all financial arrangements with each resident, next of kin who has entered into financial arrangements with the facility on behalf of the resident, and/or guardian. Copies of the record shall be accessible to the resident, next of kin who has entered into financial arrangements with the facility on behalf of the resident, or guardian during normal business hours or by prior arrangement.
- (b) The facility shall provide the resident with 30 days prior written notice of charges, expenses, or other financial liabilities that are in addition to the agreed per diem rate. The resident's prior written approval for additional charges shall not be required in the event of a health emergency that requires the resident to receive immediate special services or supplies.
- (c) Funds deposited with a facility for a particular resident's use and safekeeping shall be held in an account which is separate from any of the facility's operating accounts.
  - 1. Funds in excess of \$ 50.00 shall be deposited in an interest bearing account(s) and all interest earned on resident's funds shall be credited to that account.
  - 2. If a resident's personal funds do not exceed \$ 50.00, they shall be maintained in a separate interest bearing account, a non-interest bearing account, or a petty cash fund.

3. The facility shall assure the security of all personal funds of residents deposited with the facility, through purchase of a surety bond or an alternative that provides protection equivalent to a surety bond.
- (d) All residents who have advanced a security deposit to a facility prior to or upon admission shall be entitled to receive interest earnings which accumulate on such funds or property.
1. The facility shall hold such funds or property in trust for the resident and they shall remain the property of the resident. All such funds shall be held in an interest-bearing account as established under the requirements of N.J.S.A. 30:13-1 et seq.
  2. The facility may deduct an amount not to exceed one percent per annum of the amount so invested or deposited for costs of servicing and processing the accounts.
  3. The facility, within 60 days of establishing an account, shall notify the resident, in writing, of the name of the bank or investment company holding the funds and the account number. The facility shall thereafter provide a quarterly statement to each resident it holds security funds in trust for, identifying the balance, interest earned, and any deductions for charges or expenses incurred in accordance with the terms of the contract or agreement of admission.

#### **§ 8:39-9.6 Mandatory policies and procedures for advance directives**

- (a) The facility shall develop and implement procedures to ensure that there is a routine inquiry made of each adult resident, upon admission to the facility and at other appropriate times, concerning the existence and location of an advance directive. If the resident is incapable of responding to this inquiry, the facility shall have procedures to request the information from the resident's family or in the absence of a family member, another individual with personal knowledge of the resident. The procedures shall assure that the resident or family's response to this inquiry is documented in the medical record. Such procedures shall also define the role of facility admissions, nursing, social service and other staff as well as the responsibilities of the attending physician or advanced practice nurse.
- (b) The facility shall develop and implement procedures to promptly request and take reasonable steps to obtain a copy of currently executed advance directives from all residents. These shall be entered when received into the medical record of the resident.
- (c) A resident shall be transferred to another health care facility only for a valid medical reason, in order to comply with other applicable laws or Department rules, to comply with clearly expressed and documented resident choice, or in conformance with the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq., in the instance of private, religiously affiliated health care institutions who establish policies defining circumstances in which it will decline to participate in the implementation of advance directives. Such institutions shall provide notice to residents or their families or health care representatives prior to or upon admission of their policies. A timely and respectful transfer of the individual to another institution which will implement the resident's advance directive shall be effected. The facility's inability to care for the resident shall be considered a valid medical reason. The sending facility shall receive approval from a physician or advanced practice nurse and the receiving health care facility before transferring the resident.

- (d) The facility shall, in consultation with the attending physician or advanced practice nurse, take all reasonable steps to effect the appropriate, respectful and timely transfer of residents with advance directives to the care of an alternative health care professional in those instances where a health care professional declines as a matter of professional conscience to participate in withholding or withdrawing life-sustaining treatment. In those instances where the health care professional is the resident's physician or advanced practice nurse, the facility shall take reasonable steps, in cooperation with the physician or advanced practice nurse, to effect the transfer of the resident to another physician's or advanced practice nurse's care in a responsible and timely manner. Such transfer shall assure that the resident's advance directive is implemented in accordance with their wishes within the facility, except in cases governed by (c) above.
- (e) The facility shall have procedures to provide each adult resident upon admission, and where the resident is unable to respond, to the family or other representative of the resident, with a written statement of their rights under New Jersey law to make decisions concerning the right to refuse medical care and the right to formulate an advance directive. Such statement shall be issued by the Commissioner. Appropriate written information and materials on advance directives and the institution's written policies and procedures concerning implementation of such rights shall also be provided. Such written information shall also be made available in any language which is spoken as a primary language, by more than 10 percent of the population served by the facility.
- (f) The facility shall develop and implement procedures for referral of residents requesting assistance in executing an advance directive or additional information to either staff or community resource persons who can promptly advise and/or assist the resident.
- (g) The facility shall develop and implement policies to address application of the facility's procedures for advance directives to residents who experience an urgent life-threatening situation.
- (h) The facility shall develop and implement policies and procedures for the declaration of death of residents, in instances where applicable, in accordance with N.J.S.A. 26:6-1 et seq. and the New Jersey Declaration of Death Act, N.J.S.A. 26:6A-1 et seq. (P.L. 1991, c.90). Such policies shall also be in conformance with rules promulgated by the New Jersey Board of Medical Examiners which address declaration of death based on neurological criteria (N.J.A.C. 13:35-6A), including the qualifications of physicians or advanced practice nurses authorized to declare death based on neurological criteria and the acceptable medical criteria, tests, and procedures which may be used. The policies and procedures shall also accommodate a resident's religious beliefs with respect to declaration of death.
- (i) The facility shall establish procedures for considering disputes among the resident, health care representative and the attending physician concerning the resident's decision-making capacity or the appropriate interpretation and application of the terms of an advance directive to the resident's course of treatment. The procedures may include consultation with an institutional ethics committee, a regional ethics committee or another type of affiliated ethics committee, or with any individual or individuals who are qualified by their background and/or experience to offer clinical and ethical judgments.
- (j) The facility shall establish a process for residents, families, and staff to discuss and address questions and concerns relating to advance directives and decisions to accept or refuse medical treatment.
- (k) The facility shall provide periodic community education programs, individually or in coordination with other area facilities or organizations, that provide information to

consumers regarding advance directives and their rights under New Jersey law to execute advance directives.

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

## **SUBCHAPTER 10. ADVISORY ADMINISTRATION**

### **§ 8:39-10.1 Advisory policies and procedures for administration**

- (a) The administrator monitors trends in staff turnover.
- (b) Each of at least five service directors participates in facility planning through preparation of annual budgets and annual reports, and participates in annual budget conferences among all service directors and the administrators.

### **§ 8:39-10.2 Advisory staff qualifications**

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

### **§ 8:39-10.3 Advisory staff education and training**

- (a) Personnel who provide direct resident care are offered an opportunity to attend at least one education program each year and receive fee reimbursement or compensatory time off. Records of continuing education programs attended are maintained.
- (b) The facility conducts a tuition aid program directed toward the career development and upward mobility of staff, including both professional and ancillary personnel.
- (c) The facility is a teaching nursing home, that is, the site of an internship, externship, or residency training program for health professionals, as part of the curriculum of an accredited or State-approved school or training program. The facility has sought input from the residents and/or the resident council concerning teaching programs.
- (d) The facility maintains a library of textbooks and/or recent periodicals on long-term care, geriatric care, nursing, and other disciplines that is accessible to staff.

## **SUBCHAPTER 11. MANDATORY RESIDENT ASSESSMENT AND CARE PLANS**

### **§ 8:39-11.1 Mandatory completion of resident assessment and coordination of care plans**

A registered professional nurse (RN) shall assess the nursing needs of each resident, coordinate the written interdisciplinary care plan, sign and date the assessment to certify that it is complete, and ensure the timeliness of all services.

### **§ 8:39-11.2 Mandatory policies and procedures for resident assessment and care plans**

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

- (b) Each physician or advanced practice nurse order shall be executed by the nursing, dietary, social work, activities, rehabilitation or pharmacy service, as appropriate in accordance with professional standards of practice.
- (c) Each resident shall be examined by a physician or advanced practice nurse within five days before, or 48 hours after, admission.
- (d) An initial assessment and care plan shall be developed on the day of admission and shall address all immediate needs, including, but not limited to, personal hygiene, dietary needs, medications, and ambulation.
- (e) A comprehensive assessment shall be completed for each resident within 14 days of admission, utilizing the Standardized Resident Assessment Instrument (Minimum Data Set 2.0, or version current as of time of assessment, incorporated herein by reference).
  - 1. The complete assessment and care plan shall be based on oral or written communication and assessments provided by nursing, dietary, resident activities, and social work staff; and when ordered by the physician or advanced practice nurse, assessments shall also be provided by other health professionals.
  - 2. The care plan shall include measurable objectives with interventions based on the resident's care needs and means of achieving each goal.
  - 3. Each facility shall have the equipment and software necessary to enter, store, and transmit each resident's Standardized Resident Assessment Instrument (MDS 2.0 or most current version) electronically to the Department and shall transmit such data to the Department. The facility shall use software which meets technical specifications for the MDS 2.0 (or the version current at the time of assessment) as required by the U.S. Health Care Financing Administration at 42 CFR 483.20(b), and published in the Federal Register at 63 FR 2896.
    - i. Additional information is available from the MDS Automation Program, 609-984-8204 and at <http://www.hcfa.gov/medicaid/mds20/mds20.pdf>.
- (f) The complete care plan shall be established and implementation shall begin within 21 days, and shall include, if appropriate, rehabilitative/restorative measures, preventive intervention, and training and teaching of self-care.
- (g) If a resident is discharged to a hospital and returns to the facility within 30 days of discharge, reassessment shall be conducted in those areas where the resident's needs have changed substantially. A complete reassessment shall be performed if the resident was discharged for more than 30 days.
- (h) There shall be a scheduled comprehensive reassessment in each service involved in the initial assessment, plus other areas which the physician, advanced practice nurse, or interdisciplinary team indicates are necessary. Reassessments shall be performed according to time frames established in the previous care plan.
- (i) A reassessment shall be performed in response to all substantial changes in the resident's condition, such as fractures, onset of debilitating chronic diseases, loss of a loved one, or recovery from depression.
- (j) The facility shall have a written transfer agreement with one or more hospitals for emergency care and inpatient and outpatient services.

**HISTORY:**

Administrative correction.

See: 33 N.J.R. 4101(b).

**CASE NOTES**

N.J.A.C. 8:39-11.2(b) (now subsection (c)) and the DHSS regulation requiring that a physician visit a patient every 30 days were clearly not regulations administered by the Board of Medical Examiners for purposes of a license suspension/revocation hearing brought pursuant to N.J.S.A. 45:1-21; the clearly stated purpose of the regulations is to regulate long-term care facilities, and any remedies for deficiencies fall solely on the facility. In re Suspension or Revocation of License of Anama, OAL Dkt. No. BDS 2628-02, 2007 N.J. AGEN LEXIS 394, Initial Decision (June 11, 2007).

**SUBCHAPTER 12. ADVISORY RESIDENT ASSESSMENT AND CARE PLANS****§ 8:39-12.1 Advisory policies and procedures for resident assessment and care plan**

- (a) The resident care plan is developed at a meeting held by an interdisciplinary team that includes professional and/or ancillary staff from each service providing care to the resident.
- (b) The facility makes care planning meetings available at mutually agreeable times, including evenings and weekends, for the convenience of families and significant others.

**§ 8:39-12.2 Advisory resident services for off-site services**

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

**SUBCHAPTER 13. MANDATORY COMMUNICATION****§ 8:39-13.1 Mandatory communication policies and procedures**

- (a) Each service shall maintain a current manual of policies and procedures for providing services.
- (b) The administrative staff shall retain a written current manual of policies and procedures for the facility as a whole and for each individual service.
- (c) The facility shall notify any family promptly of an emergency affecting the health or safety of a resident.
- (d) The facility shall notify the attending physician or advanced practice nurse promptly of significant changes in the resident's medical condition.
- (e) The facility shall promptly notify a family member, guardian or other designated person about a resident's death.
  - 1. Notification shall be made at the time of the pronouncement of the resident's death, and the time between the pronouncement of the resident's death and notification shall not exceed one hour unless the family member, guardian or other designated person to be contacted provided other instructions as to when the required notification is to occur.
  - 2. The facility shall enter any alternate instructions in the resident's record alongside the contact information.
  - 3. The facility shall maintain confirmation and written documentation of that notification.



4. The facility shall adopt and maintain in its manual of policies and procedures a delineation of the responsibilities of the facility's staff in making such prompt notification regarding the death of a resident as required by this paragraph.

**HISTORY:**

Amended by R.2006 d.331, effective September 18, 2006.

See: 37 N.J.R. 4150(a), 38 N.J.R. 3896(a).

Added (e).

**§ 8:39-13.2 Mandatory resident communication services**

- (a) Residents and their families shall be given the opportunity to participate in the development and implementation of the care plan, and their involvement shall be documented in the resident's medical record.
- (b) Before or on the day of admission, residents and families shall be informed in writing about services provided by the facility, charges imposed for services at the facility, the availability of financial assistance, the rights and responsibilities of residents and families, and the role of each service on the health care team; and they shall be given a tour of resident care units in the facility.
- (c) The facility shall listen to the views and act upon or respond to the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

**§ 8:39-13.3 Mandatory staff communication qualifications**

- (a) Shall introduce and identify themselves to residents as required and necessary.
- (b) The facility shall ensure that all staff, including staff members not fluent in English, are able to communicate effectively with residents and families.

**§ 8:39-13.4 Mandatory staff education and training for communication**

- (a) Each service shall conduct an orientation program for new employees of that service unless the orientation program is conducted by the administrator or a qualified designee.
  1. For purposes of complying with this requirement, "new employees" shall be defined to include all permanent and temporary resident care personnel, nurses retained through an outside agency, and persons providing services by contract.
  2. The orientation program shall begin on the first day of employment.
  3. The orientation program for all staff shall include orientation to the facility and the service in which the individual will be employed, at least a partial tour of the facility, a review of policies and procedures, identification of individuals to be contacted under specified circumstances, and procedures to be followed in case of emergency.
- (b) Each service shall provide education or training for all employees in the service at least four times per year and in response to resident care problems, implementation of new procedures, technological developments, changes in regulatory standards, and staff member suggestions. All staff members shall receive training at least two times per year about the facility's infection control procedures, including handwashing and personal hygiene requirements.

- (c) At least one education training program each year shall be held for all employees on each of the following topics:
1. Procedures to follow in case of emergency;
  2. Abuse, neglect, or misappropriation of resident property;
    - i. Abuse prevention strategies including, but not limited to, identifying, correcting, and intervening in situations where abuse, neglect, or misappropriation of resident property is likely to occur;
    - ii. Identifying events, such as suspicious bruising of residents or patterns and trends that may constitute abuse, neglect, or misappropriation of resident property;
    - iii. Protecting residents from harm during an investigation of abuse, neglect, or misappropriation of resident property;
    - iv. Identification of staff responsible for investigating and reporting results to the proper authorities;
    - v. Reporting substantiated incidents to the appropriate local/State/Federal agencies and taking all necessary corrective actions depending on the results of the investigation; and
    - vi Reporting to the State nurse aide registry or licensing authorities any knowledge of any actions of any court of law which would indicate that an employee is unfit for service;
  3. Resident rights;
  4. Training in the specialized care of residents who are diagnosed by a physician as having Alzheimer's disease. The required training program shall be in conformance with the curriculum developed by the Department in accordance with N.J.S.A. 26:2M-7.2 (for certified nurse aides, licensed practical nurses, registered professional nurses and other health care professionals who provide direct care to residents within the facility);
    - i. Copies of the mandatory training program may be obtained from the Department by submitting a written request to:

Certification Program  
Division of Healthcare Facilities Evaluation and Licensing  
New Jersey State Department of Health and Senior Services  
PO Box 367  
Trenton, NJ 08625-0367; and
  5. Pharmacy (for all direct care staff).

**HISTORY:**

Amended by R.2005 d.164, effective June 6, 2005.  
See: 36 N.J.R. 3616(a), 37 N.J.R. 2019(a).  
In (c), added a new 4 and recodified former 4 as 5.  
Amended by R.2007 d.83, effective March 19, 2007.  
See: 38 N.J.R. 4141(a), 39 N.J.R. 924(a).  
In (c)4i, updated address.

## **SUBCHAPTER 14. ADVISORY COMMUNICATION**

### **§ 8:39-14.1 Advisory resident services**

- (a) The facility has one or more wellness programs open to the public, such as programs to reduce or prevent smoking, alcohol and drug abuse, elder abuse, obesity, or hypertension.
- (b) Periodic meetings are open to all staff, residents, and families to discuss any problems, encourage the resident to reach his or her potential, examine the goals and expectations of different individuals, describe how questions and complaints can be presented, and review the concept of interdisciplinary care.
- (c) Provision is made for residents to retain membership, join, and/or participate in community activities. These should include organizations, community projects, holiday observances, or charitable events.
- (d) A facility newsletter is provided to residents and families at least quarterly.
- (e) Each staff member wears an easily readable name tag.

### **§ 8:39-14.2 Advisory staff education and training for communication**

- (a) Periodic meetings are held with each service to discuss ways to improve care of all residents.
- (b) Education and training of staff includes an accredited program in cardiopulmonary resuscitation (CPR) which offers staff an opportunity to be recertified on an annual basis.
- (c) Each service establishes and implements education or training programs for members of other services on diverse topics.
- (d) Education or training sessions are offered which address new concepts and directions in cultural and interpersonal concepts.

## **SUBCHAPTER 15. MANDATORY DENTAL SERVICES**

### **§ 8:39-15.1 Mandatory resident dental services**

- (a) The facility shall provide or arrange emergency dental care to relieve pain and infection.
- (b) The facility shall assist interested residents in making arrangements to receive dental examinations, routine prophylaxis, and care.
- (c) The facility shall ensure that arrangements are made to transport residents for routine and emergency dental care.
- (d) All resident dentures shall be labeled.

## **SUBCHAPTER 16. ADVISORY DENTAL SERVICES**

### **§ 8:39-16.1 Advisory resident dental services**

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

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

## **SUBCHAPTER 17. MANDATORY DIETARY SERVICES**

### **§ 8:39-17.1 Mandatory structural organization for dietary services**

- (a) The facility shall designate a full-time food service director who, if not a dietitian, functions with scheduled consultation from a dietitian. The food service director shall be responsible for the direction, provision, and quality of dietary services.
- (b) Menus shall be planned and scheduled by the food service director or the dietitian, and shall be approved by the dietitian at least 14 days in advance.
- (c) The dietitian shall perform the dietary assessment and reassessment, which shall include examination of and communication with the resident if the resident's condition permits.
- (d) Services that are provided by a food service company shall be covered by a written contract.

### **§ 8:39-17.2 Mandatory policies and procedures for dietary services**

- (a) The facility shall make available a current dietary manual, which shall have been approved by the dietitian and the medical director. The facility shall serve diets that are consistent with the dietary manual.
- (b) The facility shall post current menus with portion sizes in the food preparation area. The facility shall keep menus for 30 days with any changes accurately recorded.
- (c) The facility shall designate responsibility for observation and documentation of meals refused or missed by a resident and of any resident who requires assistance with meals.
- (d) A dietitian shall adhere to an established system of nutritional assessment, which shall include examination of and communication with the resident if the resident's condition permits.
- (e) The facility shall routinely provide nondisposable dishes and cutlery at all meals except for special meal activities or individual resident needs.
- (f) Meals shall be scheduled in such a way that no more than 14 hours elapse between a substantial evening meal and breakfast the next morning. The first meal shall not be served before 7:00 A.M. unless requested by the resident.
  - 1. Up to 16 hours may elapse between a substantial evening meal and breakfast the following day if the following conditions are met:
    - i. A resident group agrees to this meal span; and
    - ii. A nourishing bedtime snack is served.
- (g) All food service facilities shall operate with safe food handling practices in accordance with Chapter XII of the New Jersey Sanitary Code, N.J.A.C. 8:24.

**§ 8:39-17.3 Mandatory staffing amounts and availability for dietary services**

- (a) The dietitian shall spend an average of 15 minutes per resident each month providing dietary services in the facility, which requires one full-time equivalent dietitian for every 693 residents.
- (b) Dietary service personnel shall be present for a period of at least 12 hours each day.
- (c) For each meal, the facility shall assign staff to help residents who require assistance with eating.

**§ 8:39-17.4 Mandatory resident dietary services**

- (a) Each resident shall receive a diet which:
  - 1. Corresponds to the physician's or advanced practice nurse's order, the dietitian's instructions, and resident's food preferences;
  - 2. Is served in the proper consistency and at the proper temperature; and
  - 3. Provides nutrients and calories based upon current recommended dietary allowances of the National Academy of Sciences, adjusted for the resident's age, sex, weight, physical activity, physiological function, and therapeutic needs.
- (b) The facility shall provide between-meal and bedtime nourishment, and beverages shall be available at all times for each resident unless contraindicated by a physician, as documented in the resident's medical record.
- (c) The facility shall offer substitute foods and beverages to all residents who refuse the food served at meal times. Such substitutes shall be of equivalent nutritional value and planned in advance in writing.
- (d) No resident shall have to wait for assistance in eating for more than 15 minutes following delivery of a tray to the resident.
- (e) The facility shall select foods and beverages, which include fresh and seasonal foods, and shall prepare menus with regard to the nutritional and therapeutic needs, cultural backgrounds, food habits, and personal preference of residents.

**SUBCHAPTER 18. ADVISORY DIETARY SERVICES****§ 8:39-18.1 Structural organization for dietary services**

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

**§ 8:39-18.2 Advisory staff qualifications for dietary services**

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

**§ 8:39-18.3 Advisory staffing amounts and availability for dietary services**

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

**§ 8:39-18.4 Advisory resident dietary services**

- (a) There are dietary observances for national and/or religious holidays.
- (b) Fresh fruits and vegetables are served in season on a daily basis.
- (c) The facility utilizes a dining room/area, other than day rooms, for residents with special needs.
- (d) Residents have access to a refrigerator or snack bar.
- (e) Residents are offered a selective menu consisting of at least three main entrees at each meal.
- (f) A menu committee composed of residents participates in meal planning.
- (g) The facility sponsors a guest meal program.

**§ 8:39-18.5 Supplies and equipment**

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

**SUBCHAPTER 19. MANDATORY INFECTION CONTROL AND SANITATION****§ 8:39-19.1 Mandatory organization for infection control and sanitation**

- (a) The facility shall have an infection prevention and control program conducted by an infection control committee which shall include representatives from at least administrative, nursing, medical, dietary, housekeeping or environmental services, and pharmacy staffs. The infection control committee shall review all infection control policies and procedures, periodically review infection control surveillance data, and formulate recommendations to the administrator regarding infection control activities.
- (b) Responsibility for the infection prevention and control program shall be assigned to an employee who is designated as the infection control coordinator, with education, training, completed course work, or experience in infection control or epidemiology; or services shall be provided by contract. If the services are provided by contract, the facility shall designate an on-site employee to implement, coordinate, and ensure compliance with infection control policies and procedures.

**§ 8:39-19.2 Mandatory employee health policies and procedures for infection control and sanitation**

- (a) Employees who have signs or symptoms of a communicable disease shall not be permitted to perform functions that expose residents to risk of transmission of the disease.
- (b) If a communicable disease prevents the employee from working, a physician's or advanced practice nurse's statement approving the employee's return shall be required. Prior to the employee's return to work, the physician's or advanced practice nurse's statement shall be reviewed by the administrator or the administrator's designee. However, when an employee has been absent for no longer than three days, the employee's return to work may be approved by either the facility's director of nursing or the infection control committee, following assessment by a registered professional nurse.

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

### **§ 8:39-19.3 Mandatory waste removal policies and procedures**

- (a) Regulated medical waste shall be collected, stored, handled, and disposed of in accordance with applicable Federal laws and regulations, and the facility shall comply with the provisions of N.J.S.A. 13:1E-48.1 et seq., the Comprehensive Regulated Medical Waste Management Act, and all rules promulgated pursuant to the aforementioned Act including, but not limited to, N.J.A.C. 7:26-3A.
- (b) The infection control committee shall develop and implement written policies and procedures for collection, storage, handling, and disposal of all solid waste that is not regulated medical waste.
- (c) All solid waste that is not regulated medical waste shall be disposed of in a sanitary landfill or other manner approved by the Department of Environmental Protection. Disposal shall be as frequent as necessary to avoid creating a nuisance.

### **§ 8:39-19.4 Mandatory general policies and procedures for infection control and sanitation**

- (a) The facility shall develop, implement, comply with, and review, at least annually, written policies and procedures regarding infection prevention and control which are consistent with the most up-to-date Centers for Disease Control and Prevention publications, incorporated herein by reference, including, but not limited to, the following:
1. Guidelines for Handwashing and Hospital Environmental Control;
  2. Guidelines for Isolation Precautions in Hospitals;
  3. Prevention and Control of Tuberculosis in Facilities Providing Long-term Care to the Elderly;
  4. Prevention of Nosocomial Pneumonia;
  5. Prevention of Catheter Associated Urinary Tract Infections; and
  6. Prevention of Intravascular Infections.
- (b) Centers for Disease Control and Prevention publications can be obtained from:
- National Technical Information Service  
U.S. Department of Commerce  
5285 Port Royal Road  
Springfield, VA 22161  
or  
Superintendent of Documents  
U.S. Government Printing Office  
Washington, D.C. 20402
- (c) The facility shall comply with applicable current Occupational Safety and Health Administration (OSHA) requirements.
- (d) The infection control coordinator shall provide continuous collection and analysis of data, including determination of nosocomial infections, epidemics, clusters of infections, infections due to unusual pathogens or multiple antibiotic resistant bacteria, and any occurrence of nosocomial infection that exceeds the usual baseline levels.

- (e) The infection control coordinator shall make recommendations for corrective actions based on surveillance and data analysis.
- (f) The facility shall have a system for investigating, evaluating, and reporting the occurrence of all reportable infections and diseases as specified in Chapter II of the State Sanitary Code (N.J.A.C. 8:57-1).
- (g) The facility shall maintain listings of all residents and personnel who have reportable infections, diseases, or conditions.
- (h) The facility shall document evidence of annual vaccination against influenza for each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused the vaccine, in accordance with N.J.A.C. 8:39-4.1(a)4. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year. Residents admitted after this date, during the flu season and up to February 1, shall, as medically appropriate, receive influenza vaccination prior to or on admission, unless refused by the resident.
- (i) The facility shall document evidence of vaccination against pneumococcal disease for all residents who are 65 years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused offer of the vaccine in accordance with N.J.A.C. 8:39-4.1(a)4. The facility shall provide pneumococcal vaccination to residents who have not received this immunization, prior to or on admission unless the resident refuses offer of the vaccine.
- (j) The facility shall implement a policy for tuberculosis screening of all residents which begins prior to admission and concludes within 30 days following admission. If the admission screening is conducted through chest X-ray within three months prior to admission, the resident shall receive a two-step Mantoux skin test within three months after admission.
- (k) If used, all reusable respiratory therapy equipment and instruments that touch mucous membranes shall be disinfected or sterilized in accordance with the Centers for Disease Control and Prevention publication "Guidelines for Handwashing and Hospital Environmental Control," and with manufacturer's recommendations.
- (l) Disinfection procedures for items that come in contact with bed pans, sinks, and toilets shall conform with established protocols for cleaning and disinfection, in accordance with the Centers for Disease Control publication "Guidelines for Handwashing and Hospital Environmental Control," and with manufacturer's recommendations. All resident care items shall be cleaned, disinfected, or sterilized, according to the use of the item.
- (m) All residents shall be provided with an opportunity to wash their hands before each meal and shall be encouraged to do so. Staff shall wash their hands before each meal and before assisting residents in eating. Handwashing practices shall be monitored at least monthly by the infection control coordinator.
- (n) Personnel shall wash their hands with soap and warm water for between 10 and 30 seconds or use other effective hand sanitation techniques immediately prior to contact with residents.

**HISTORY:**

Amended by R.2002 d.58, effective March 4, 2002.



See: 33 New Jersey Register 2751(a), 34 New Jersey Register 1040(b).  
Added new (h) and (i) and recodified former (h) through (l) as (j) through (n).

### **§ 8:39-19.5 Mandatory staff qualifications; health history and examinations**

- (a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.
- (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows:
  - 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.
  - 2. If the Mantoux test is significant (10 millimeters or more of induration), a chest x-ray shall be performed and, if necessary, followed by chemoprophylaxis or therapy.
  - 3. Any employee with positive results shall be referred to the employee's personal physician or advanced practice nurse and if active tuberculosis is suspected or diagnosed shall be excluded from work until the physician or advanced practice nurse provides written approval to return.
- (c) The facility shall have written policies and procedures requiring annual Mantoux tuberculin skin tests for all employees, except those exempted under (b) above.
- (d) The facility shall assure that all current employees who have not received the two-step Mantoux test upon employment, except those exempted by (b) above, shall receive a test. The facility shall act on the results of tests of current employees in the same manner as prescribed in (b) above.

### **§ 8:39-19.6 Mandatory space and environment for water supply**

- (a) The water supply used for drinking or culinary purposes shall be adequate in quantity, of a safe sanitary quality, and from a water system which shall be constructed, protected, operated, and maintained in conformance with the New Jersey Safe Drinking Water Act, N.J.S.A. 58:12A-1 et seq., N.J.A.C. 7:10 and local laws, ordinances, and regulations. Copies of the Safe Drinking Water Act can be obtained from the Department of Environmental Protection, Bureau of Safe Drinking Water, PO Box 426, Trenton, New Jersey 08625-0426.
- (b) There shall be no cross connections between city and well water supplies. When the facility uses well water for potable water every day, a double check valve shall be

permitted if the facility has approval for such use from the water company and the New Jersey State Department of Environmental Protection.

- (c) The facility shall post water quality test results in at least one conspicuous location in the facility, in accordance with N.J.S.A. 26:2H-12.14.
- (d) Equipment requiring water drainage, such as ice machines and water fountains, shall be properly drained to a sanitary connection.

### **§ 8:39-19.7 Mandatory space and environment for sanitation and waste management**

- (a) Solid waste shall be stored in clean, solidly constructed containers with tight-fitting lids for the storage of solid wastes.
- (b) Storage areas for solid waste containers shall be kept clean. Waste shall be collected from all storage areas regularly to prevent nuisances such as odors, flies, or rodents.
- (c) There shall be no back siphonage conditions present.
- (d) All food service facilities shall be maintained in conformance with Chapter XII of the New Jersey State Sanitary Code, N.J.A.C. 8:24.
- (e) If the facility has an incinerator, it shall operate with the necessary permits from the New Jersey Department of Environmental Protection and shall not create a nuisance to the facility or the community.
- (f) Solid waste that is not regulated medical waste shall be stored within the containers provided for it outside the facility or in a separate room that is maintained in a clean and sanitary condition. Waste shall be collected from the storage room regularly to prevent nuisances such as odors, flies, or rodents, and so that the waste shall not overflow or accumulate beyond the capacity of the storage containers.
- (g) Garbage compactors shall be located on an impervious pad that is graded to a drain. For new construction, the drain shall be connected to the sanitary sewage disposal system.
- (h) Plastic bags shall be used for solid waste removal from resident care units and supporting departments. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal.

### **§ 8:39-19.8 Mandatory supplies and equipment for infection control and sanitation**

- (a) The sewage disposal system shall be maintained in good repair and operated in compliance with State and local laws, ordinances, and regulations.
- (b) Water piping carrying non-potable water shall be clearly labeled.
- (c) Commercial sterile supplies shall be used in accordance with manufacturers' recommendations, and before expiration dates, and packages shall be inspected to ensure integrity.
- (d) Bed pan washers shall be in good working order and properly maintained.
- (e) Toilet tissue and proper waste receptacles shall be provided.
- (f) Suitable hand cleanser and sanitary towels or approved hand-drying machines shall be provided.
- (g) Equipment and supplies used for sterilization, disinfection, and decontamination purposes shall be maintained according to manufacturers' specifications.

## **SUBCHAPTER 20. ADVISORY INFECTION CONTROL AND SANITATION**

### **§ 8:39-20.1 Advisory policies and procedures for infection control**

- (a) The facility routinely offers Hepatitis B vaccine to all employees, regardless of risk status or duties, without charge.
- (b) Employees undergo periodic or annual health screening.
- (c) The facility maintains records documenting contagious diseases contracted by employees during employment.

### **§ 8:39-20.2 Advisory staff qualifications**

- (a) The infection control coordinator is certified in Infection Control (CIC) by the National Board of Infection Control, P.O. Box 14661, Lenexa, KS 66286-4661.
- (b) The infection control coordinator is an active member of the National Association for Professionals in Infection Control and Epidemiology, Inc. (APIC), 1275 K Street, NW, Suite 1000, Washington, DC 20005-4006.
- (c) The infection control coordinator has completed an APIC Basic Training Course or has received at least 25 hours of training in infection control, and receives an additional six hours of training annually.

### **§ 8:39-20.3 Advisory staff education and training for infection control**

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

## **SUBCHAPTER 21. MANDATORY LAUNDRY SERVICES**

### **§ 8:39-21.1 Mandatory laundry policies and procedures**

- (a) Soiled laundry shall be stored in a ventilated area, separate from other supplies, and shall be stored, sorted, rinsed, and laundered only in areas specifically designated for those purposes.
- (b) All soiled laundry from resident rooms and other service units shall be stored, transported, collected, and delivered in a covered laundry bag or cart. Laundry carts shall be in good repair, kept clean, and identified for use with either clean or soiled laundry.
- (c) Soiled laundry contaminated with blood and/or body fluids shall be collected in an effectively closed leak proof bag of sufficient strength to safely contain such laundry from point of origin to point of processing.
- (d) Clean laundry shall be protected from contamination during processing, storage, and transportation within the facility.
- (e) Soiled and clean laundry shall be kept separate.
- (f) An established protocol, reviewed by the infection control committee, shall be followed to reduce the number of bacteria in the fabrics.
- (g) Equipment surfaces that come into contact with laundry shall be sanitized.

- (h) The facility shall develop and implement policies and procedures, reviewed by the infection control committee, to protect staff from contamination when handling soiled laundry.
- (i) Sour testing to ensure neutralization of alkaline residues from built detergents shall be conducted, and fabric pH shall be maintained at 7.0 or below after souring.
- (j) The facility shall develop and implement policies and procedures to ensure that residents' personal clothing is collected, processed and returned to the resident in a sanitary manner and in good condition.
- (k) The facility shall have a system to identify each resident's clothing and a procedure to locate and/or minimize loss of clothing.

### **§ 8:39-21.2 Mandatory space and environment for laundry facilities**

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

### **§ 8:39-21.3 Mandatory supplies and equipment for laundry**

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

### **§ 8:39-21.4 Mandatory quality assurance for laundry**

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

## **SUBCHAPTER 22. (RESERVED)**

### **§ 8:39-22 (RESERVED)**

## **SUBCHAPTER 23. MANDATORY MEDICAL SERVICES**

### **§ 8:39-23.1 Mandatory structural organization for medical services**

- (a) Each facility shall have a medical director who is currently licensed to practice medicine by the New Jersey State Board of Medical Examiners.
  - 1. The medical director shall coordinate medical care and direct the administrative aspects of medical care in the facility.
  - 2. The medical director shall approve all medical care policies and procedures. These policies and procedures shall be followed.
  - 3. The medical director shall participate in the facility's quality assurance program through attendance at meetings, or interviews, and/or preparation or review of reports.

4. The medical director shall be an active participant on the facility's infection control committee, pharmacy and therapeutics committee, and a committee that is responsible for developing policies and procedures for resident care.
  5. The medical director shall ensure that for each resident there is a designated primary and an alternate physician who can be contacted when necessary.
  6. The medical director shall review all reports of incidents that have been documented in accordance with N.J.A.C. 8:39-9.4(e)4.
  7. The medical director, or physicians designated by the medical director, shall respond quickly and effectively to medical emergencies that are not handled by another attending physician, including inpatient admissions.
- (b) In facilities providing pediatric care services, the medical director/attending physician shall be board-certified, or eligible to be board-certified, by the American Board of Pediatrics or American Board of Family Practice.
- (c) Facilities with fewer than 60 beds may develop an alternate system of medical direction, if the facility can document that medical staff perform the requirements at (a)1 through 4 above.

### § 8:39-23.2 Mandatory medical services

- (a) Each physician or advanced practice nurse order shall be properly entered into the resident's medical record.
- (b) Each resident's attending physician or advanced practice nurse shall review the resident's medical record on a scheduled basis to ensure that care plans and medical orders are properly followed.
- (c) The facility shall maintain a list of consultant physicians who are available for referrals made by the attending physician and shall make arrangements for referrals to psychological services.
- (d) A physician or advanced practice nurse shall visit each resident at least every 30 days unless the medical record contains an explicit justification for not doing so. Following the initial visit, alternate 30-day visits may be delegated by a physician to a New Jersey licensed physician assistant, in accordance with facility policies.

### CASE NOTES

N.J.A.C. 8:39-11.2(b) (now subsection (c)) and the DHSS regulation requiring that a physician visit a patient every 30 days were clearly not regulations administered by the Board of Medical Examiners for purposes of a license suspension/revocation hearing brought pursuant to N.J.S.A. 45:1-21; the clearly stated purpose of the regulations is to regulate long-term care facilities, and any remedies for deficiencies fall solely on the facility. In re Suspension or Revocation of License of Anama, OAL Dkt. No. BDS 2628-02, 2007 N.J. AGEN LEXIS 394, Initial Decision (June 11, 2007).

### § 8:39-23.3 Defibrillator

- (a) The facility shall maintain at least one defibrillator available to trained staff in a central location.
- (b) The facility shall have a written protocol on the use of the defibrillator. The protocol shall address:
  1. The testing and maintenance of the defibrillator according to the manufacturer's operational guidelines; and
  2. The training of staff in the use of the defibrillator.

- (c) The facility shall arrange and pay for the training of a sufficient number of direct-care staff in cardio-pulmonary resuscitation and the proper use of the defibrillator to ensure that at least one direct-care staff member on every shift holds a current certification from the American Red Cross, American Heart Association or other training program recognized by the Department in cardio-pulmonary resuscitation and the use of the defibrillator.
- (d) The facility shall notify the appropriate first aid, ambulance or rescue squad or other appropriate emergency medical services provider of the type of defibrillator acquired

**HISTORY:**

New Rule by R.2005 d.400, effective November 21, 2005.

See: 37 N.J.R. 1932(a), 37 N.J.R. 4437(a).

**SUBCHAPTER 24. ADVISORY MEDICAL SERVICES****§ 8:39-24.1 Advisory medical staff qualifications**

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

**§ 8:39-24.2 Advisory resident medical services**

- (a) The facility arranges for physician or advanced practice nurse visits in the facility on a scheduled appointment basis in an office provided for that purpose.
- (b) The facility has a staff or consultant psychiatrist with admitting privileges to the inpatient psychiatric unit at a hospital.

**SUBCHAPTER 25. MANDATORY NURSE STAFFING****§ 8:39-25.1 Mandatory policies and procedures for nurse staffing**

- (a) There shall be a full-time director of nursing or nursing administrator who is a registered professional nurse licensed in the State of New Jersey, who has at least two years of supervisory experience in providing care to long-term care residents, and who supervises all nursing personnel.
- (b) During a temporary absence of the director of nursing, there shall be a registered professional nurse on duty who shall be designated in writing as an alternate to the director of nursing. The alternate shall be temporarily responsible for supervising all nursing personnel.

**SUBCHAPTER 25. MANDATORY NURSE STAFFING****§ 8:39-25.2 Mandatory nurse staffing amounts and availability**

- (a) The facility shall provide nursing services and licensed nursing and ancillary personnel at all times. In accordance with N.J.A.C. 13:37-6.2, the registered professional nurse may delegate selected nursing tasks in the implementation of the nursing regimen to licensed practical nurses and ancillary nursing personnel.
- (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of:

1. Total number of residents multiplied by 2.5 hours/day; plus
2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:

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

(c) The following definitions shall be used for nursing services set forth in (b)2 above:

1. Wound care includes, but is not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites. In this category are Stage II pressure sores encompassing two or more distinct lesions on separate anatomical sites, and State III and Stage IV pressure sores.
  - I. Tube site and surrounding skin related to ostomy feeding is not to be counted as wound care unless there are complicating factors, such as: exudative, suppurative or ulcerative inflammation which require specific physician or advanced practice nurse prescribed intervention provided by the licensed nurse beyond routine cleansing and dressing.
  - ii. Stage III and Stage IV are defined as follows:
    - (1) Stage III: The wound extends through the epidermis and dermis into the subcutaneous fat and is a full thickness wound. There may be inflammation, necrotic tissue, infection and drainage and undermining sinus tract formation. The drainage can be serosanguinous or purulent. The area is painful.
    - (2) Stage IV: The pressure wound extends through the epidermis, dermis, and subcutaneous fat into fascia, muscle and/or bone. Eschar, undermining odor and profuse drainage may exist.
    - (3) Other wounds which may be categorized under wound care as defined in (c)1 above include:
      - (A) Open wounds which are draining purulent or colored exudate or which have a foul odor present and/or for which the individual is receiving antibiotic therapy;
      - (B) Wounds with a drain or T-tube;
      - (C) Wounds which require irrigation or instillation of a sterile cleansing or medicated solution and/or packing with sterile gauze;
      - (D) Recently debrided ulcers;

- (E) Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when dressing is changed (for example, post radical neck surgery, cancer of the vulva); and
  - (F) Open wounds, widespread skin disease or complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;
  - (G) Complicated post-operative wounds that exhibit signs of infection, allergic reactions or an underlying medical condition that affects healing.
2. Tube feedings, which include nasogastric tube and percutaneous feedings, provide the individual with more than 26 percent of his or her calories and at least 501 milliliters of hydration daily and are required to treat the individual's condition after all non-invasive avenues to improve the nutritional status have been exhausted with no improvement. The clinical record shall document the non-invasive measures provided and the individual's poor response. The record shall also indicate the medical condition for which the feedings are ordered. Included in this service is the routine care of the tube site and surrounding skin of the surgical gastrostomy.
    - i. Feeding tubes that are routinely clamped off and are no longer the primary source of dietary administration and nutritional support are covered under the basic 2.5 hours/day of nursing service and shall not be counted as an additional nursing service.
  3. Oxygen therapy includes complex provision of oxygen/respiratory therapies due to the nature of the individual's condition, the type or multiplicity of procedures required and the need for therapies for which individual is dependent upon administration by licensed staff, such as positive pressure breathing therapy, nasal BiPAP and aerosol therapy.
  4. Tracheostomy includes new tracheostomy sites and complicated cases involving symptomatic infections and unstable respiratory functioning.
  5. Intravenous therapy includes clinically indicated therapies ordered by the physician, such as central venous lines, Hickman/Broviac catheters, heparin locks, total parenteral nutrition, clysis, hyperalimentation and peritoneal dialysis. When clinically indicated, intravenous medications should be appropriately and safely administered within prevailing medical protocols. If intravenous therapy is for the purpose of hydration, the clinical record shall document any preventive measures and attempts to improve hydration orally, and the individual's inadequate response.
  6. Respirator use includes care for individuals who are stable and no longer require acute or specialized respirator programs and who require mechanical ventilation to oxygenate their blood. Ongoing assessment, intervention, and evaluation by a registered professional nurse are needed. The individual's treatment plan should include protocols for weaning the individual from assisted respiration and/or self care when clinically indicated and ordered by the physician or advanced practice nurse.
  7. Head trauma stimulation/advanced neuromuscular/orthopedic care:
    - i. Care of head trauma is directed toward individuals who are stable (have plateaued) and can no longer benefit from a rehabilitative unit or unit for specialized care of the injured head. Individuals shall have access to and periodic reviews by such specialists as a neurologist, neuropsychologist, psychiatrist and vocational rehabilitation specialist, in accordance with their



clinical needs. There shall also be contact with appropriate therapies, such as physical therapy, speech-language pathology services and occupational therapy. The distinguishing characteristic for add-on hours for head trauma is the necessity for ongoing assessment and evaluation by a registered professional nurse focusing on early identification of complications, and implementation of appropriate nursing interventions. Nursing protocols may be initiated which are specifically designed to meet individual needs of head injured individuals. The nurse may also supervise a coma stimulation program, when this need is identified by the interdisciplinary team.

- ii. Advanced neuromuscular care needs shall be identified by the physician for individuals during an unstable episode or where there is advanced and progressive deterioration in which the individual requires observation for neurological complications, monitoring, and administration of medications or nursing interventions to stabilize the condition and prevent unnecessary regression.
  - iii. Advanced orthopedic care is the care of plastered body parts with a pre-existing peripheral vascular or circulatory condition requiring observations for complications and monitoring and administration of medication to control pain and/or infection. Such care also involves additional measures to maintain mobility; care of post-operative fracture and joint arthroplasty, during the immediate subacute post-operative period involving proper alignment; teaching and counseling and follow-up to therapeutic exercise and activity regimens. Individuals in this group shall be identified by the physician as needing advanced orthopedic care. If the requirement for advanced orthopedic care exceeds 30 days, clinical need must be demonstrated and clearly documented by the interdisciplinary team.
- (d) In facilities with 150 licensed beds or more, there shall be an assistant director of nursing who is a registered professional nurse.
  - (e) A registered professional nurse shall be on duty at all times in facilities with more than 150 licensed beds.
  - (f) At least 20 percent of the hours of care required by (b) above shall be provided by individuals who are either registered professional nurses or licensed practical nurses.
  - (g) The nurse aide component of the facility's total hourly nurse staffing requirement, as specified in (b) above, shall be met by nurse aides who have completed a nurse aide training course approved by the New Jersey State Department of Health and Senior Services and have passed the New Jersey Nurse Aide Certification Examination, in accordance with N.J.A.C. 8:39-43, and/or by newly hired individuals who have worked in the facility for less than four months and who are enrolled in a nurse aide training program.
  - (h) There shall be at least one registered professional nurse on duty in the facility during all day shifts. (During a temporary absence, not to exceed 72 hours, the registered professional nurse may be on duty during the evening or night shift.)
  - (i) There shall be at least one registered professional nurse on duty or on call during all evening and night shifts.

## SUBCHAPTER 26. ADVISORY NURSE STAFFING

### § 8:39-26.1 Advisory structural organization for nurse staffing

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

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

- (a) The facility establishes and implements a system for assigning nursing personnel on the basis of a classification system involving resident acuity.
- (b) The facility uses a primary system in which nurse aides are assigned on a regular basis to specific residents to provide continuity of care.

### § 8:39-26.3 Advisory nurse staffing amounts and availability

- (a) A registered professional nurse is on duty at all times in facilities with fewer than 100 licensed beds, two registered professional nurses are on duty at all times in facilities with 100 to 200 licensed beds, and three registered nurses are on duty at all times in facilities with more than 300 beds.
- (b) The facility provides direct nursing services pursuant to N.J.A.C. 8:39-25.2(b) which are increased by at least 10 percent.
- (c) At least 50 minutes per resident per day of resident care is provided by licensed nurses, that is, registered professional nurses and licensed practical nurses. (This is an average. It is equal to one full-time equivalent nurse for every ten residents.)
- (d) All nurse aides working in the facility have completed a training and orientation program to all services of at least two weeks full-time duration within the facility prior to their permanent assignment in the facility.
- (e) Each resident care unit in the facility meets the nurse staffing requirements mandated in N.J.A.C. 8:39-25.2(b).

### § 8:39-26.4 Advisory qualifications for nurse staffing

- (a) The director of nursing has a baccalaureate or master's degree in nursing or a health-related field.
- (b) An advanced practice nurse who is Board certified in family, adult, or geriatric practice is available on staff or under contract with the facility to perform assessments and to provide consultation to other staff members.
- (c) The facility employs an advanced practice nurse certified in gerontology or psychiatric nursing on at least a half time basis.
- (d) A nurse who holds certification in gerontological nursing, rehabilitation nursing, or a related field of nursing from the American Nurses Credentialing Center of the American Nurses Association, is available on staff or under contract with the facility.

**SUBCHAPTER 27. MANDATORY QUALITY OF CARE****§ 8:39-27.1 Mandatory policies, procedures and practices for quality of care**

- (a) The facility shall provide and ensure that each resident receives all care and services needed to enable the resident to attain and maintain the highest practicable level of physical (including pain management), emotional and social well-being, in accordance with individual assessments and care plans.
- (b) All resident care policies shall be written and developed by a resident care committee, shall be available to physicians, advanced practice nurses, staff, residents, their relatives or guardians, and the public, and shall be implemented in accordance with acceptable professional standards of practice.
- (c) The interdisciplinary committee or equivalent shall develop, review at least annually, revise as needed, and ensure implementation of written policies and procedures for the use of restraints and assure that the facility continuously attempts to eliminate the need for restraints. Guidance for such policies and procedures is provided in Appendix D of this chapter. Policies shall include the collection of the following data:
  - 1. All emergency restraint applications;
  - 2. Indicators for the frequency of the use of restraints in the facility;
  - 3. Evaluation of all cases in which there is:
    - i. A failure to obtain or receive a physician's or advanced practice nurse's order;
    - ii. A negative clinical outcome; and
  - 4. Indicators of the frequency of the use of psychopharmacological agents.
- (d) All nursing and professional staff of the facility shall receive orientation and annual training in the use of restraints, including at least:
  - 1. Emergency and non-emergency procedures;
  - 2. Practice in the application of restraints and alternative methods of intervention; and
  - 3. Interventions by licensed and non-licensed nursing personnel.
- (e) The facility shall take preventive measures against the development of pressure sores, including assessing the resident's skin daily and minimizing friction and pressure against clothing and bed linens. When present, pressure sores shall be identified, documented, and treated.
- (f) The facility shall conduct a bladder and bowel retraining program for selected residents on a 24-hour basis with results documented.

**CASE NOTES**

Testimony and evidence presented on a nursing home resident's behalf failed to articulate a proper basis for reimbursing the \$ 29,000 cost of a specialized wheelchair because federal law requires that the Division of Medical Assistance and Health Services avoid the unnecessary utilization of services, the wheelchair was not medically necessary for the diagnosis or treatment of a disease, injury, or condition in accordance with N.J.A.C. 10:49-5.5(a)1, and the Medicaid program does not cover durable medical equipment when not considered cost-effective for a beneficiary's treatment. Specifically, providing necessary assistance to the resident in the resident's current wheelchair was within the nursing staff's responsibility and was care already included in the rate the Division paid to the nursing facility as a Medicaid provider, and the resident would not have been able to leave the nursing home in

the foreseeable future. J.R. v. DMAHS, OAL Dkt. No. HMA 10958-04, 2005 N.J. AGEN LEXIS 1317, Final Decision (October 14, 2005).

### § 8:39-27.2 Mandatory resident services for personal care

- (a) Residents shall be weighed accurately every month. Whenever there is a gain or loss of five percent or more, a note shall be entered into the medical record stating whether the care plan should be modified. If the resident cannot be weighed, alternate measures shall be used to monitor weight change.
- (b) Nonambulatory residents shall be repositioned at least once every two hours.
- (c) Effective and safe measures shall be taken to ensure that residents do not harbor parasitic insects.
- (d) Effective and safe measures shall be taken to ensure that residents are not malodorous.
- (e) Any dehydrated and/or malnourished resident shall be accurately evaluated and effectively treated.
- (f) Oral hygiene care shall be offered to the resident by staff on a daily basis.
- (g) The resident's hair and nails shall be groomed.
- (h) Each resident shall be kept clean and dry.
- (i) Each resident shall receive at least one bath (tub or shower) per week unless contraindicated.
- (j) Each resident's bed shall be made daily. Clean linen shall be provided for each resident at least once a week or whenever linens are soiled or wet.
- (k) Each resident shall have access to fresh drinking water or juice at all times, unless contraindicated.
- (l) Non-bedfast residents shall be provided with the means for leaving and returning to their beds and rooms each morning and afternoon.
- (m) Measures to prevent contractures shall be used, and contractures shall be identified, documented, and managed by rehabilitative nursing and physical therapy.
- (n) Indwelling catheters shall not be used for the convenience of staff.

### § 8:39-27.3 Mandatory general resident services

- (a) Residents shall be afforded the opportunity to eat in a group setting unless contraindicated with the reasons noted in the resident's medical record. The need for feeding assistance shall not constitute an acceptable contraindication.
- (b) Residents shall be afforded an opportunity to go outdoors on a regular basis.
- (c) Clothing, including undergarments and footwear, shall be clean, comfortable, and personally assigned to each resident, and shall reflect personal preference and safety. The facility shall promote residents' sense of personal control in acquiring clothing, for example, through the establishment of a clothing concession in the facility or clothing vendors' periodic visits to the facility, the arrangement of shopping excursions, and/or the use of catalogue shopping by residents.
- (d) Residents shall be encouraged and helped to select the clothing they will wear each day.

**§ 8:39-27.4 Mandatory post-mortem policies and procedures**

- (a) Deceased residents shall be removed in a timely fashion from rooms where other residents are staying and transported within the facility in a dignified manner.
- (b) A family member, guardian, or other designated person shall be promptly notified at the time of the pronouncement of the resident's death.
  - 1. The facility shall maintain in the resident's medical record confirmation and written documentation of that notice.
- (c) Deceased residents shall receive post-mortem care, including cleaning and shrouding in conformance with each resident's religious practices.
- (d) The deceased shall not be removed from the facility until pronounced dead with the death documented in the resident's medical record. Prosthesis shall accompany the body out of the facility.
- (e) The body of a deceased resident who, at the time of death, had a communicable disease as defined in N.J.A.C. 8:57-1.3 shall be tagged accordingly before being released from the facility.
- (f) Personal effects and financial accounts of deceased residents shall be safeguarded.

**HISTORY:**

Amended by R.2006 d.331, effective September 18, 2006.

See: 37 N.J.R. 4150(a), 38 N.J.R. 3896(a).

Rewrote the introductory paragraph of (b); and inserted (b)1.

Amended by R.2009 d.107, effective April 6, 2009.

See: 40 N.J.R. 1962(a), 41 N.J.R. 1419(a).

In (e), updated the N.J.A.C. reference.

**§ 8:39-27.5 Mandatory supplies and equipment for resident care**

- (a) Prostheses, including eyeglasses, dentures, and hearing aids, shall be functional and individualized, and shall be kept available to the resident, unless the resident specifically rejects their use.
- (b) Adaptive devices and equipment shall be functional and individualized, and shall be kept available to the resident unless the resident specifically rejects their use.
- (c) All drinking water containers shall be washed daily and sanitized weekly. Containers that cannot be sanitized shall be discarded.
- (d) The facility shall maintain at least one bag-valve-mask resuscitator.
- (e) Bath thermometers or other temperature controls shall be used to monitor the temperatures of each bath or shower.

**SUBCHAPTER 28. ADVISORY QUALITY OF CARE****§ 8:39-28.1 Advisory policies and procedures for resident care**

- (a) The facility conducts scheduled interdisciplinary staff discussions, and discussions with residents and families, about the right of residents to die with dignity.
- (b) The facility develops and provides individualized non-restrictive equipment meeting individual needs which fosters and supports a restraint-free environment for all residents.

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

### **§ 8:39-28.2 Advisory resident care services**

- (a) There are education programs provided on at least a quarterly basis, open and accessible to residents, families, and significant others addressing the following issues:
  - 1. The enhancement and maintenance of physical and mental well-being;
  - 2. The prevention of deterioration;
  - 3. The teaching of self-care; and
  - 4. Death, dying and bereavement.
- (b) There are education and training programs provided on at least a quarterly basis, open and accessible to families and significant others, which teach skills and help in the provision of support services that enable residents to leave the facility for visits and vacations.
- (c) Donated clothing is made available so that residents can select desired items.
- (d) The facility provides a non-commercial washer and dryer for residents who wish to launder their own personal items.

## **SUBCHAPTER 29. MANDATORY PHARMACY**

### **§ 8:39-29.1 Mandatory pharmacy organization**

- (a) A facility shall have a consultant pharmacist and either a provider pharmacist or, if the facility has an in-house pharmacy, a director of pharmaceutical services.
- (b) A New Jersey licensed pharmacist shall serve as director of pharmaceutical services or as consultant pharmacist. The pharmacist shall comply with Federal and State statutes, rules, regulations and currently accepted standards of practice.
- (c) The facility shall have an interdisciplinary pharmacy and therapeutics committee, appointed by and reporting to the administrator and consisting of at least the administrator, a representative of the nursing staff, and the consultant pharmacist, with oversight as needed by the medical director. The committee may include a licensed pharmacist representing the provider pharmacy. The committee shall hold meetings as needed but at least quarterly and records, including the dates of meetings, attendance, activities, findings, and recommendations, shall be maintained.
- (d) The facility shall appoint a consultant pharmacist who is not also the director of pharmaceutical services or pharmacist provider and does not have an affiliation with either the director of pharmaceutical services or the pharmacist provider.
- (e) If the facility keeps emergency injectable or oral controlled substances, a current Drug Enforcement Administration registration and Controlled Dangerous Substance registration for that location shall be available. (See N.J.S.A. 24:21-10 for registration requirements; registration application procedures are specified at N.J.A.C. 8:65-1.4.)

### **§ 8:39-29.2 Mandatory drug administration policies and procedures**

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

- (b) The facility shall have a system to accurately identify recipients before any drug is administered.
- (c) Self-administration of drugs shall be permitted by qualified residents only as specified by the policy of the pharmacy and therapeutics committee and the assessment of the interdisciplinary team. Self-administration procedures shall include, at a minimum, the following:
  - 1. The written order of the prescriber;
  - 2. Storage of medications in the resident's room, based on resident assessments;
  - 3. Specifications for labeling, including directions for use;
  - 4. Methods for documentation in the medical record, based on resident assessment;
  - 5. Training of residents in self-administration by the nursing staff or the consultant pharmacist; and
  - 6. Policies for individual assessment of residents' ability to self-administer medications.
- (d) Medications shall be accurately administered and documented by properly authorized individuals, as per prescribed orders and stop order policies.

### **§ 8:39-29.3 Mandatory pharmacy reporting policies and procedures**

- (a) The consultant pharmacist shall conduct a drug regimen review and enter appropriate comments into the medical record of every resident receiving medication, at least monthly, on a pharmacist consultation sheet or another portion of the medical record in accordance with N.J.A.C. 13:39. The drug regimen review shall be performed in accordance with Federal and State statutes, rules and regulations, and currently accepted standards of practice for rational drug therapy.
  - 1. The consultant pharmacist shall report any irregularities promptly to the attending physician or advanced practice nurse and to the director of nurses and these reports shall be acted upon. These reports shall include, but are not limited to, problems and recommendations about drug therapy which may be affected by biologicals, laboratory tests, special dietary requirements and foods used or administered concomitantly with other medication to the same recipient. Also, these reports are required to include monitoring for potential adverse effects, allergies, drug interactions, contraindications, rationale, and drug evaluation.
  - 2. Drug product defects and adverse drug reactions shall be reported in accordance with the ASHSP-USP-FDA (American Society of Health System Pharmacists, United States Pharmacopoeia, Food and Drug Administration) Drug Product Defect Reporting System and the USP Adverse Drug Reaction Reporting System.
  - 3. All known drug allergies shall be documented in the resident's medical record including the medication administration records and physician or advanced practice nurse order sheets and on the outside front cover and communicated to the provider or dispensing pharmacy.
  - 4. Drugs that are not specifically limited as to duration of use or number of doses shall be controlled by automatic stop orders. The resident's attending physician or advanced practice nurse shall be notified of the automatic stop order prior to the last dose so that he or she may decide whether to continue use of the drug.
  - 5. If medication is withheld, the reason for withholding the medication shall be documented in the resident's medical record.

6. Medication errors and adverse drug reactions shall be reported immediately to the director of nursing or the alternate to the director of nursing, and a description of the error or adverse drug reaction shall be entered into the medical record before the end of the employee shift. If the resident has erroneously received medication, the resident's physician or advanced practice nurse shall be notified immediately. If a medication error originated in the pharmacy, the pharmacy shall be notified immediately. The Department shall be notified of an adverse drug reaction that results in death.

#### **§ 8:39-29.4 Mandatory pharmacy control policies and procedures**

- (a) The label of each resident's individual medication container or package shall be labeled in accordance with the New Jersey State Board of Pharmacy regulations at N.J.A.C. 13:39-5.9, permanently affixed, and contain the following information:
  1. The resident's full name;
  2. The prescriber's name;
  3. The prescription number;
  4. The name and strength of drug;
  5. The quantity dispensed;
  6. The lot number;
  7. The date of issue;
  8. The expiration date;
  9. The manufacturer's name if generic;
  10. Cautionary and/or accessory labels.
    - i. If a generic substitute is used, the drug shall be labeled according to the Drug Utilization Review Council Formulary, N.J.S.A. 24:6E-1 et seq. and N.J.A.C. 8:71.
    - ii. Required information appearing on individually packaged drugs or within an alternate medication delivery system need not be repeated on the label; and
  11. The name, address, and telephone number of the pharmacy.
- (b) If a unit dose distribution system is used ("unit dose drug distribution" means a system in which drugs are delivered to the resident areas in single unit packaging), the following requirements shall be met:
  1. Each resident shall have his or her own medication tray labeled with the resident's name and location in the facility;
  2. Each medication shall be individually wrapped and labeled with the generic or trade (brand) name and strength of the drug, lot number or reference code, expiration date, dose, and manufacturer's name, and shall be ready for administration to the resident;
  3. Cautionary instructions shall appear on the resident's record of medication, and the system shall include provisions for noting additional information, including, but not limited to, special times or routes of administration and storage conditions; and
  4. Delivery and exchange of resident medication trays shall occur promptly, and, if a 24-hour unit-dose system is used, then at least one exchange of resident medication trays shall occur every 24 hours, including weekends and holidays.



- (c) Both over-the-counter and prescription medications may be kept as stock. A limited amount of prescription medications may be kept as stock for the administration of stat (emergency) doses, lost doses, or doses not sent by the provider pharmacy. These medications shall be approved by the pharmacy and therapeutics committee, monitored for accountability, and labeled to include drug name, drug strength, manufacturers' name, lot number, expiration date, recommended dosage for over-the-counter medications, and applicable cautionary and/or accessory labels.
- (d) The consultant pharmacist shall:
1. Make monthly inspection of all areas in the facility where medications are dispensed, administered, or stored;
  2. Periodically, as determined by the quality assurance program, observe a medication pass and review the crediting system; and
  3. Document any problems and propose solutions to these problems.
- (e) The contents of emergency kits shall have been approved by the pharmacy and therapeutics committee. Emergency kits shall be stored securely at each nursing unit, but not kept under lock and key, checked after each use, and checked at least monthly by the consultant pharmacist. Emergency kits shall not be accessible to residents but shall be accessible to staff in a timely manner.
- (f) All medications repackaged by the pharmacy shall be labeled with an expiration date, name and strength of drug, lot number, date of issue, manufacturer's name if generic, and cautionary and/or accessory labels, in accordance with N.J.A.C. 13:39-5.9, United States Pharmacopoeia (U.S.P.) requirements and applicable FDA regulations.
- (g) The pharmacy and therapeutics committee shall establish and enforce procedures for removal of discontinued, unused, expired, recalled, deteriorated, and unlabeled drugs and intravenous solutions and for removal of containers of medications with worn, illegible, damaged, incomplete, or missing labels.
- (h) All medications shall be stored in accordance with manufacturers' and United States Pharmacopoeia (U.S.P.) requirements and all medications shall be kept in locked storage areas.
- (i) All medication destruction in the facility shall be witnessed by at least two persons, each of whom shall be either the pharmacist consultant, a registered professional nurse or a licensed practical nurse. A record of each instance of drug destruction shall be maintained.
- (j) Where allowable by law, the facility shall generate a crediting mechanism for medications dispensed in a unit-of-use drug distribution system, or other system that allows for the re-use of medications. The crediting system shall be monitored by the provider pharmacist and a facility representative.
- (k) The pharmacy and therapeutics committee shall establish and enforce procedures for the inventory of controlled substances in accordance with law.
- (l) Based on prescriber's orders for medications, drug tests, diet and treatments, the facility shall implement written methods and procedures for obtaining prescribed prescription medications and biologicals from a pharmacy that has a permit from the New Jersey State Board of Pharmacy, in accordance with N.J.A.C. 13:39-4. The telephone number of the pharmacy and procedures for obtaining drugs shall be posted at each nursing unit.
- (m) If the facility utilizes drugs marked "sample", the pharmacy and therapeutics committee shall develop a mechanism for the control and limitation of these drugs, in accordance with N.J.A.C. 13:35-6.6.

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

### **CASE NOTES**

Although pharmacy was not a "facility" as defined in a long term care facility regulation, N.J.A.C. 8:39-1.2, because the pharmacy acted as a long term care facility's mandatory pharmacy provider, N.J.A.C. 8:39-29.4(j) and 8:39-1.2 required the pharmacy to "observe, watch, or check" the long term care facility's crediting system; however, the obligation to monitor did not require the pharmacy to credit Medicaid for returned medications. *United States ex rel. Quinn v. Omnicare Inc.*, 382 F.3d 432, 2004 U.S. App. LEXIS 18474 (3d Cir. N.J. 2004).

### **§ 8:39-29.5 Mandatory pharmacy staff qualifications**

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

### **§ 8:39-29.6 Mandatory resident pharmacy services**

- (a) The facility shall provide pharmaceutical services, either directly or by contract with a provider pharmacy, 24 hours a day, seven days a week.
- (b) If a resident obtains medications from a pharmacy that is not the facility provider pharmacy, the following conditions shall be met:
1. The pharmacy provider shall comply with all labeling requirements specified at N.J.A.C. 8:39-29.4(a); and
  2. The facility shall establish a plan for obtaining the resident's drugs on an emergency basis.
- (c) A resident may obtain medications from a pharmacy that is not the facility provider pharmacy unless:
1. The resident is expressly informed during the admission process and within the admission agreement that this service is not permitted in the facility; or
  2. For existing residents, the facility submits documentation to the Department, prior to denying the request, demonstrating a significant risk to the health and safety of residents as a result of this practice.

### **§ 8:39-29.7 Mandatory pharmacy supplies and equipment**

- (a) Medication containers and carts shall be handled properly to prevent damage, injury and harm.
- (b) Needles and syringes shall be stored, used, and disposed of in accordance with New Jersey State law, and a record shall be maintained of the purchase, storage, and disposal of needles and syringes.
- (c) Controlled substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts and all other Federal and State laws and regulations concerning procurement, storage, dispensation, administration, and disposition.

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

### **§ 8:39-29.8 Mandatory pharmacy quality assurance**

The pharmacy and therapeutics committee shall review reports of medication errors and suspected adverse drug reactions and shall summarize these reports yearly.

## **SUBCHAPTER 30. ADVISORY PHARMACY**

### **§ 8:39-30.1 Advisory pharmacy staffing amounts and availability**

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

### **§ 8:39-30.2 Advisory pharmacy resident services**

The consultant pharmacist reviews drug records within 48 hours of admission via a facsimile service. All dated and signed comments and recommendations made by the consultant pharmacist shall be added to the resident's medical record and shall be distributed to the attending physician or advanced practice nurse and director of nurses for review and action.

### **§ 8:39-30.3 Advisory provider formulary criteria**

The provider pharmacy through the Pharmacy and Therapeutics Committee, may establish a formulary which is not in contradiction to the Drug Utilization Review Council Formulary, N.J.S.A. 24:6E-1 et seq., and N.J.A.C. 8:71. The formulary policies must be approved by the Pharmacy and Therapeutics Committee and every prescriber with prescriptive authority in the facility. The Pharmacy and Therapeutics Committee establishes policies for the prescribing of non-formulary agents. The formulary is developed to avoid negative outcomes.

### **§ 8:39-30.4 Advisory consultant pharmacist certification**

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

## **SUBCHAPTER 31. MANDATORY PHYSICAL ENVIRONMENT**

### **§ 8:39-31.1 Mandatory construction standards**

- (a) No construction, renovation or addition shall be undertaken without first obtaining approval from the Department, Long-Term Care Licensing and Certification Program and/or the Department of Community Affairs, Health Care Plan Review Unit.
- (b) New construction, alterations and additions of long-term care facilities shall comply with the Uniform Construction Code (N.J.A.C. 5:23) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Construction Code may be obtained from the Construction Code Element of the Department of Community Affairs, PO Box 805, Trenton, New Jersey 08625-0805.
- (c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the

Fire Safety Element of the Department of Community Affairs, PO Box 809, Trenton, New Jersey 08625-0809.

- (d) Required annual maintenance inspections by the Department of Health and Senior Services for a facility participating in the Medicare or Medicaid programs shall be conducted in accordance with the edition of the National Fire Protection Associations Life Safety Code that has been adopted by the Federal Health Care Financing Administration, incorporated herein by reference as amended and supplemented; however, this code shall not be enforced to exceed the requirements of the Uniform Construction Code referenced in (b) above. A facility that does not participate in either the Medicare or Medicaid programs shall be inspected under the version of the Life Safety Code in effect at the time of original licensure; however, this code shall not be enforced to exceed the requirements of the Uniform Construction Code referenced in (b) above. (Copies of the Life Safety Code may be obtained from the National Fire Protection Association, Battery March Park, Quincy,

### **§ 8:39-31.2 Mandatory general maintenance**

- (a) Personnel engaged in general maintenance activities shall receive orientation upon employment and, at least once a year, education or training in principles of asepsis, cross-infection control, and safe practices.
- (b) There shall be a system for reporting physical plant, safety, and maintenance problems to a designated staff member and documentation of the correction of such problems.
- (c) A current, written preventive maintenance program shall be implemented. Records of inspections and repairs shall be maintained for at least one year.
- (d) Written instructions for operating and maintaining equipment shall be systematically retained and followed.
- (e) The facility shall be kept in good repair and maintained without harm or jeopardy to residents.
- (f) There shall be a maintenance contract on elevators that includes routine maintenance inspections.
- (g) The standby emergency power generator shall be checked weekly, tested under load monthly, and serviced in accordance with generally accepted engineering practices.
- (h) Temperature shall be in accordance with requirements specified in the 1996-97 edition of "Guidelines For Design and Construction of Hospital and Health Care Facilities" (American Institute of Architects Academy of Architecture for Health, with assistance from the U.S. Department of Health and Human Services. The American Institute of Architects Press: Washington, DC), incorporated herein by reference that apply, depending on the time the building was constructed.
- (i) There shall be a comprehensive, current, written preventive maintenance program for the electrical system that is documented and followed.

### **§ 8:39-31.3 Mandatory quality assurance for housekeeping**

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

### **§ 8:39-31.4 Mandatory housekeeping policies and procedures**

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

- (b) The facility shall have a written schedule that determines the frequency of cleaning and maintaining all equipment, structures, areas, and systems.
- (c) Mattresses, mattress pads and coverings, pillows, bedsprings, and other furnishings shall be properly maintained and kept clean and replaced as needed. They shall be thoroughly cleaned and disinfected on a regular schedule and whenever a new resident is using them.
- (d) Scatter rugs shall be not permitted and floors shall be coated with slip-resistant floor finish.
- (e) Carpeting shall be kept clean and odor free and shall not be frayed, worn, torn, or buckled.
- (f) All equipment and environmental surfaces shall be clean to sight and touch.

### **§ 8:39-31.5 Pest control**

- (a) Effective and safe controls shall be used to minimize and eliminate the presence of rodents, flies, roaches and other vermin in the facility.
  - 1. The premises shall be kept in such condition as to prevent the breeding, harborage, or feeding of vermin.
  - 2. All openings to the outer air shall be effectively protected against the entrance of insects.

### **§ 8:39-31.6 Mandatory fire and emergency preparedness**

- (a) Employees shall be trained in procedures to be followed in an emergency operations plan and instructed in the use of fire fighting equipment and resident evacuation of the buildings as part of their initial orientation and at least annually thereafter.
- (b) Fire drills shall be conducted a total of 12 times per year, with at least one drill on each shift and one drill on a weekend. The facility shall attempt to have the local fire department participate in at least one fire drill per year. An actual alarm shall be considered a drill if it is documented.
- (c) Fire regulations and procedures shall be posted in each unit and/or department. A written evacuation diagram that includes evacuation procedures and locations of fire exits, alarm boxes, and fire extinguishers shall be posted conspicuously on a wall in each resident care unit and/or department throughout the facility.
- (d) There shall be a procedure for investigating and reporting fires. All fires shall be reported to the Department immediately by phone and followed up in writing within 72 hours. In addition, a written report of the investigation by the fire department containing all pertinent information shall be forwarded to the Department as soon as it becomes available.
- (e) Smoking regulations shall be developed, implemented, and enforced in accordance with N.J.S.A. 26:3D-1 et seq. and 26:3D-7 et seq.
  - 1. Residents shall not be permitted to smoke in their rooms and in other secluded areas. The facility may enforce a no-smoking rule for staff and visitors.
  - 2. Restricted smoking areas shall be designated and rules governing such smoking promulgated and rigidly enforced. Nonflammable ashtrays in sufficient numbers shall be provided in permitted smoking areas. In any area where smoking is permitted, there shall be adequate outside ventilation.

3. At the facility's option, it may institute a smoke-free policy. Any prospective smoke-free policy shall be set forth in the facility's admission agreement and shall only apply to residents entering the facility on or after the policy's effective date. The facility shall protect the rights of residents who smoke by providing a designated area with adequate outside ventilation for controlled smoking. If inside, the designated smoking room shall be adequately ventilated to prevent recirculation of smoke to other areas of the facility. If outside, the designated area shall provide reasonable protection from inclement weather.
- (f) The facility shall have a written comprehensive emergency operations plan developed in coordination with the local office of emergency management. This plan shall:
1. Identify potential hazards that could necessitate an evacuation, including natural disasters, national disasters, industrial and nuclear accidents, and labor work stoppage;
  2. Identify the facility and an alternative facility to which residents would be relocated, and include signed, current agreements with the facilities;
  3. Identify the number, type and source of vehicles available to the facility for relocation and include signed current agreements with transportation providers. Specially configured vehicles shall be included;
  4. Include a mechanism for identifying the number of residents, staff, and family members who would require relocation and procedures for evacuation of non-ambulatory residents from the facility;
  5. List the supplies, equipment, records, and medications that would be transported as part of an evacuation, and identify by title the individuals who would be responsible;
  6. Identify essential personnel who would be required to remain on duty during the period of relocation;
  7. Identify by title and post in a prominent place the name(s) of the persons who will be responsible for the following:
    - i. Activating the emergency operations plan, issuing evacuation orders, and notifying of State and municipal authorities;
    - ii. Alerting and notifying of staff and residents;
    - iii. Facility shutdown and restart;
    - iv. In place sheltering of residents and continuity of medical care; and
    - v. Emergency services such as security and firefighting; and
  8. Describe procedures for how each item in (f)7 above will be accomplished.
- (g) There shall be a written plan for receiving residents who are being relocated from another facility due to a disaster. This plan shall include at least an estimate of the number and type of residents the facility would accommodate and how staffing would be handled at different occupancy levels.
- (h) Copies of the emergency operations plan shall be sent to municipal and county emergency management officials for their review.
- (i) The administrator shall serve as, or appoint, a disaster planner for the facility.
1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan, or if county or municipal officials are

- unavailable for this purpose, the facility shall notify the State Office of Emergency Management.
2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents.
- (j) Any staff member who is designated as the acting administrator shall be knowledgeable about and authorized to implement the facility's plans in the event of an emergency.
  - (k) All staff shall be oriented to the facility's current plans for receiving and evacuating residents in the event of a disaster, including their individual duties.
  - (l) The facility shall ensure that residents receive nursing care throughout the period of evacuation and return to the original facility.
  - (m) The facility shall ensure that evacuated residents who are not discharged are returned to the facility after the emergency is over.
  - (n) The facility shall maintain at least a three-day supply of food and have access to an alternative supply of water in case of an emergency.
  - (o) The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance.
  - (p) The facility shall establish a written heat emergency action plan which specifies procedures to be followed in the event that the indoor air temperature is 82 degrees Fahrenheit or higher for a continuous period of four hours or longer.
    1. These procedures shall include the immediate notification of the Department of Health and Senior Services.
    2. In implementing a heat emergency action plan, a facility shall not prevent a resident from having a room temperature in his or her resident room in excess of 82 degrees Fahrenheit if the resident and the resident's roommate, if applicable, so desire, and if the resident's physician approves.
    3. A heat emergency plan need not be implemented if the resident care areas are not affected by an indoor temperature in excess of 82 degrees Fahrenheit.
    4. The heat emergency action plan shall include a comprehensive series of measures to be taken to protect residents from the effects of excessively high temperatures.

### **§ 8:39-31.7 Mandatory safety requirements**

- (a) An outlet that is connected to an emergency power supply shall be used wherever life-sustaining equipment is in operation.
- (b) All draperies, curtains, and wastebaskets shall be maintained flame retardant.
- (c) All decorations shall be flame retardant. Open flames used for decoration or religious ceremonies shall not be left unsupervised.
- (d) Cooking equipment shall be properly installed and maintained.
- (e) Lint traps in clothes dryers shall be kept in a clean and safe condition.
- (f) Kerosene heaters and staff and resident-owned heating devices shall not be permitted.
- (g) Extension cords shall not be permitted unless they are provided by the maintenance or engineering department of the facility, inspected regularly, and inventoried by the

maintenance and engineering department. Extension cords shall be for temporary use only in resident care areas.

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

### **§ 8:39-31.8 Mandatory space and environment; all facilities**

- (a) The facility shall provide for and operate adequate ventilation in all areas used by residents. All areas of the facility used by residents shall be equipped with air conditioning and the air conditioning shall be operated so that the temperature in these areas does not exceed 82 degrees Fahrenheit.
- (b) All exit doors to the facility shall be kept externally locked from 8:00 P.M. until 6:30 A.M.
- (c) All residents shall have, in their rooms:
1. A bed and a mattress of the correct size to fit the bed;
  2. Sheets, blankets, a pillow, and additional pillow if required or desired;
  3. A bed table with drawer;
  4. A separate closet area and shelves for personal needs;
  5. A privacy curtain around the bed excepting private rooms;
  6. An unobstructed doorway;
  7. Window coverings that are properly mounted and maintained;
  8. Night lights;
  9. Call bells immediately accessible to the resident in bed or an individual at bedside;
  10. A comfortable chair for each resident in his or her room for use by the resident or resident's visitor;
  11. An individual light for each resident in a room;
  12. Supplies for oral needs, including a denture cup, if needed, and a clean toothbrush;
  13. A basin, comb, and bedpan and/or urinal unless clearly unnecessary, stored in an appropriate storage space convenient to the resident; and
  14. A waste receptacle.
- (d) Glare from windows and reflections on floors and tables in the multi-purpose or dining room shall be controlled.
- (e) All supplies and equipment in the facility shall be of such quality as not to break or tear easily.
- (f) Each facility shall provide:
1. Good lighting at entrances and, where applicable, in parking areas;
  2. A walker or a tripod cane to each resident who requires mechanical assistance to walk; and
  3. A wheelchair to each resident who is not ambulatory.



**SUBCHAPTER 32. ADVISORY PHYSICAL ENVIRONMENT****§ 8:39-32.1 Advisory general maintenance**

- (a) Inspections or rounds are conducted at least monthly by a designated person or committee on all units and areas for maintenance problems. Results of these rounds are reported to the administrator.
- (b) Maintenance services are under the supervision of an employee with at least one of the following:
  - 1. Five years of experience in maintaining a physical plant;
  - 2. A baccalaureate degree in engineering from an accredited college or university and two years of experience in maintaining a physical plant; or
  - 3. Professional licensure in New Jersey as an engineer with one year of experience in maintaining a physical plant.

**§ 8:39-32.2 Advisory fire and emergency preparedness**

- (a) The facility conducts at least two evacuation drills each year, either simulated or using selected residents, at least one of which is conducted on a weekend or during an evening or night work shift. Results of the drills are to be summarized in a written report, which is shared with the county and municipal emergency management coordinators.
- (b) A municipal, county, or State emergency management official conducts an education or training program in the facility on disaster planning and emergency preparedness at least once a year.
- (c) Fire drills are conducted annually on each weekend shift.

**§ 8:39-32.3 Advisory safety**

- (a) There is a committee responsible for physical plant and resident safety and maintenance, which includes, at a minimum, representatives from administration, nursing, and maintenance services and meets at least quarterly.
- (b) Regularly scheduled training meetings are held for residents and families, addressing safety issues in the facility.

**SUBCHAPTER 33. MANDATORY QUALITY ASSESSMENT AND/OR QUALITY IMPROVEMENT****§ 8:39-33.1 Mandatory quality assessment and/or quality improvement structural organization**

- (a) Quality assessment and/or quality improvement procedures shall be developed and implemented through a written plan that specifies time frames.
- (b) Responsibility for the quality assessment and/or quality improvement program shall be assumed by designated individuals, who shall include the director of nursing services, a physician or advanced practice nurse, and at least three other staff members, and who shall report directly to the administrator.

- (c) Summary findings of the quality assessment and/or quality improvement program shall be submitted in writing to the administrator and the administrator shall take action that includes staff education or training on the basis of the program's findings.
- (d) The quality assessment and/or quality improvement program shall review at least inventory control, maintenance inspections and reports, procedures for reporting incidents and hazards, and procedures for emergency response to incidents and hazards.
- (e) Quality assessment and/or quality improvement program findings shall be presented to the administrator with recommendations for corrective actions to address problems.

### **§ 8:39-33.2 Mandatory quality assessment and/or quality improvement policies and procedures**

- (a) The quality assessment and/or quality improvement program shall identify problems in the care and services provided to the residents and shall include the audit of medical records.
- (b) The quality assessment and/or quality improvement program shall monitor the performance of each service.
- (c) The quality assessment and/or quality improvement program shall monitor trends in the following:
  - 1. The prevalence of pressure sores and skin breakdowns;
  - 2. Psychoactive drug use;
  - 3. Transfers to hospitals;
  - 4. Medication errors;
  - 5. Catheterization rates and catheterization care;
  - 6. Weight loss and fluid intake;
  - 7. Infection rates in all residents;
  - 8. Resident depression;
  - 9. Restoration of function following specific types of events, such as hip fractures;
  - 10. Use of restraints;
  - 11. Resident falls resulting in injury;
  - 12. Incidents of abuse, neglect or misappropriation of resident property; and
  - 13. Other possible indicators of level of quality care not listed in this subchapter.
- (d) The quality assessment and/or quality improvement program shall develop and implement a system to measure the effectiveness of the reassessment process with respect to frequency, comprehensiveness, accuracy, implementation, and interdisciplinary approach.

### **§ 8:39-33.3 Mandatory quality assessment and/or quality improvement of resident services**

The quality assessment and/or quality improvement program shall include the gathering of resident care information from residents and visitors.

**§ 8:39-33.4 Mandatory quality assessment and/or quality improvement of staff education and training**

The quality assessment and/or quality improvement program shall evaluate staff education programs.

**SUBCHAPTER 34. ADVISORY QUALITY ASSESSMENT AND/OR QUALITY IMPROVEMENT****§ 8:39-34.1 Advisory quality assessment and/or quality improvement policies and procedures**

- (a) The facility develops and maintains an active, continuous quality improvement process that involves staff, residents, families and/or the community in improving the quality of services provided by the facility.
- (b) The quality assessment and/or quality improvement program uses a resident classification system, such as acuities or specified diagnostic classifications, as an indicator in measuring resident outcomes.
- (c) The quality assessment and/or quality improvement program includes periodic surveys of families to ascertain their satisfaction, suggestions, knowledge of resident's health conditions and treatments, and/or knowledge of facility policies and staff members' roles.
- (d) There is a system to receive input on resident safety issues.

**SUBCHAPTER 35. MANDATORY MEDICAL RECORDS****§ 8:39-35.1 Mandatory organization for medical records**

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

**§ 8:39-35.2 Mandatory policies and procedures for medical records**

- (a) Each active medical record shall be kept at the nurses' station for the resident's unit.
- (b) The facility shall maintain for staff use a current list of standard professional abbreviations commonly used in the facility's medical records.
- (c) Medical records shall be organized with a uniform format across all records.
- (d) A medical record shall be initiated for each resident upon admission. The current medical record shall be readily available and shall include at least the following information, when such information becomes available:
  - 1. Legible identifying data, such as resident's name, date of birth, sex, address, and next of kin, and person to notify in an emergency;
  - 2. The name, address, and telephone number of the resident's physician, an alternate physician, or advanced practice nurse and dentist;
  - 3. Complete transfer information from the sending facility, including results of diagnostic, laboratory, and other medical and surgical procedures, and a copy of the resident's advance directive, if available, or notice that the resident has informed the sending facility of the existence of an advance directive;

4. A history and results of a physical examination, including weight, performed by the physician or advanced practice nurse on admission, in accordance with N.J.A.C. 8:39-11.2(c) and results of the most recent examination by the physician, or advanced practice nurse, or New Jersey licensed physician assistant;
  5. An assessment and plan of care made by each discipline involved in the resident's care;
  6. Clinical notes for the past three months incorporating written, signed and dated notations by each member of the health care team who provided services to the resident, including a description of signs and symptoms, treatments and/or drugs given, the resident's reaction, and any changes in physical or emotional condition entered into the record when the service was provided;
  7. All physician's or advanced practice nurse's orders for the last three months;
  8. Telephone orders, each of which shall be countersigned by a physician or advanced practice nurse within seven days, except for orders for non-prescription drugs or treatments, which shall be signed at the physician's or advanced practice nurse's next visit to the resident;
  9. Records of all medications and other treatments that have been provided during the last three months;
  10. Consultation reports for the last six months;
  11. Records of all laboratory, radiologic, and other diagnostic tests for the last six months;
  12. Records of all admissions, discharges, and transfers to and from the facility that occurred in the last three months;
  13. Signed consent and release forms;
  14. Documentation of the existence, or nonexistence, of an advance directive and the facility's inquiry of the resident concerning this;
  15. A discharge plan for those residents identified by the facility as likely candidates for discharge into the community or a less intensive care setting; and
  16. A discharge note written on the day of discharge for residents discharged to the community, a less intensive care setting, another nursing home or hospital, which includes at least the diagnosis, prognosis, and psychosocial and physical condition of the resident.
- (e) The medical record shall be completed within 30 days of discharge.
- (f) If part of a care plan is not implemented, the record shall explain why.
- (g) All entries in the resident's medical record shall be written legibly in ink, dated, and signed by the recording person or, if a computerized medical records system is used, authenticated.
1. If an identifier such as a master sign-in sheet is used, initials may be used for signing documentation, in accordance with applicable professional standards of practice.
  2. If computer-generated orders with an electronic signature are used, the facility shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of computer-generated signatures.

3. If a facsimile communications system (FAX) is used, entries into the medical record shall be in accordance with the following procedures:
  - i. The physician, advanced practice nurse, or New Jersey licensed physician assistant shall sign the original order, history and/or examination at an off-site location;
  - ii. The original shall be FAXed to the long-term care facility for inclusion into the medical record;
  - iii. The physician, advanced practice nurse, or New Jersey licensed physician assistant shall submit the original for inclusion into the medical record within 72 hours; and
  - iv. The FAXed copy shall be replaced by the original. If the facsimile reports are produced by a plain-paper facsimile process that produces a permanent copy, the plain-paper report may be included as a part of the medical record, as an alternate to replacement of the copy by the original report.
- (h) If a resident or the resident's legally authorized representative requests, orally or in writing, a copy of his or her medical record, a legible photocopy of the record shall be furnished at a fee based on actual costs, which shall not exceed prevailing community rates for photocopying. ("Legally authorized representative" means spouse, immediate next of kin, legal guardian, resident's attorney, or third party insurer where permitted by law.) A copy of the medical record from an individual admission shall be provided to the resident or the resident's legally authorized representative within two working days of request.
  1. The facility shall establish a policy assuring access to copies of medical records for residents who do not have the ability to pay; and
  2. The facility shall establish a fee policy providing an incentive for use of abstracts or summaries of medical records. The resident or his or her authorized representative, however, has a right to receive a full or certified copy of the medical record.
- (i) Access to the medical record shall be limited only to the extent necessary to protect the resident. A verbal explanation for any denial of access shall be given to the resident or legal guardian by the physician or advanced practice nurse and there shall be documentation of this in the medical record. In the event that direct access to a copy by the resident is medically contraindicated (as documented by a physician or advanced practice nurse in the resident's medical record), the medical record shall be made available to a legally authorized representative of the resident or the resident's physician or advanced practice nurse.
- (j) The resident shall have the right to attach a brief comment or statement to his or her medical record after completion of the medical record.
- (k) The record shall be protected against loss, destruction, or unauthorized use. Medical records shall be retained for a period of 10 years following the most recent discharge of the resident, or until the resident reaches the age of 23 years, whichever is the longer period of time. A summary sheet of each medical record shall be retained for a period of 20 years, and X-ray films or reproductions thereof shall be retained for a period of five years.

## SUBCHAPTER 36. ADVISORY MEDICAL RECORDS

### § 8:39-36.1 Advisory policies and procedures for medical records

- (a) The name by which the resident wishes to be called is entered on the cover or first page of the medical record.
- (b) There is a comprehensive discharge summary with statistical and narrative information from each service completed for each resident.
- (c) The full medical records for all discharged or deceased residents are completed within 15 days.
- (d) Telephone orders are countersigned by a physician or advanced practice nurse within 48 hours except for orders for non-prescription drugs or treatments, which are countersigned within seven days.

### § 8:39-36.2 Advisory staff education and training for medical records

The facility requires that staff use only standard professional abbreviations in medical records and maintains a current list of such abbreviations.

### § 8:39-36.3 Advisory staff qualifications for medical records

- (a) The facility utilizes the services of a medical record practitioner or consultant who is:
  1. Certified or eligible for certification as a registered record administrator (RRA) or an accredited record technician (ART) by the American Medical Record Association (American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611); or
  2. A graduate of a program in medical record science accredited by the Committee on Allied Health Education and Accreditation of the American Medical Association in collaboration with the Council on Education of the American Medical Record Association (American Medical Record Association, 875 North Michigan Avenue, Suite 1850, John Hancock Center, Chicago, Illinois 60611).

## SUBCHAPTER 37. MANDATORY REHABILITATION

### § 8:39-37.1 Mandatory policies and procedures for rehabilitation

- (a) Orders from physicians or from advanced practice nurses, to the extent allowable by applicable laws, for speech therapy, physical therapy, occupational therapy, and audiology services shall include specific modalities and the frequency of treatment, and shall be entered into the resident's medical record.
- (b) Orders from physicians or from advanced practice nurses, to the extent allowable by applicable laws, for medically appropriate speech therapy, physical therapy, occupational therapy and audiology services shall be properly followed, and the results of these services shall be entered into the resident's medical record.

### § 8:39-37.2 Mandatory rehabilitation staff qualifications

- (a) Speech therapy and audiology services shall be provided by a speech-language pathologist who holds a current New Jersey license issued by the Audiology and Speech Language Pathology Advisory Committee, Division of Consumer Affairs of the New Jersey State Department of Law and Public Safety.

- (b) Physical therapy shall be provided by a physical therapist licensed by the New Jersey State Board of Physical Therapy, or by a licensed physical therapy assistant under the direction of a licensed physical therapist, in accordance with N.J.S.A. 45:9-37.1.
- (c) Occupational therapy shall be provided by an occupational therapist who is licensed by the New Jersey Occupational Therapy Advisory Council, or by a licensed occupational therapy assistant under the direction of a licensed occupational therapist, in accordance with N.J.S.A. 45:9-37.51.

### **§ 8:39-37.3 Mandatory rehabilitation staffing amounts and availability**

Speech-language pathology evaluation, physical therapy evaluation, occupational therapy evaluation, and audiology evaluation shall take place within 72 hours of the original physician or advanced practice nurse order, excluding weekends.

### **§ 8:39-37.4 Mandatory rehabilitation supplies and equipment**

- (a) Space for rehabilitation therapy shall be provided in the facility. If space is unavailable, arrangements shall be made for transportation or transfer of residents who require rehabilitation therapy services.
- (b) Visual privacy and provisions for auditory privacy shall be provided for residents during evaluation and rehabilitation treatment, when clinically indicated.
- (c) If the facility provides physical therapy on-site, physical therapy equipment available to the residents shall include at least parallel bars, stairs, mats, and padded tables.

## **SUBCHAPTER 38. ADVISORY REHABILITATION**

### **§ 8:39-38.1 Advisory rehabilitation staff qualifications**

Speech therapy and audiology services are provided by individuals who hold a Certificate of Clinical Competence issued by the American Speech-Language-Hearing Association.

### **§ 8:39-38.2 Advisory rehabilitation space and environment**

The facility has an examination and treatment room for rehabilitation therapy.

### **§ 8:39-38.3 Advisory rehabilitation supplies and equipment**

- (a) In addition to parallel bars and stairs, physical therapy equipment available to residents includes a whirlpool for hydrotherapy and ultrasound.
- (b) The occupational therapy program provides individually designed adaptive equipment as needed to enhance residents' independence.

## **SUBCHAPTER 39. MANDATORY SOCIAL WORK**

### **§ 8:39-39.1 Mandatory social work policies and procedures**

A social worker shall develop and implement specific criteria to identify residents who are likely candidates for discharge into the community or a less intensive care setting and to coordinate discharge planning.

**§ 8:39-39.2 Mandatory social work staff qualifications**

Social work services shall be provided by one or more social workers who are certified or licensed by the New Jersey State Board of Social Work Examiners, in accordance with the Social Worker's Licensing Act of 1991 (N.J.S.A. 45:15BB-1 et seq.) and all amendments thereto and with the rules of the New Jersey Board of Social Work Examiners, N.J.A.C. 13:44G.

**§ 8:39-39.3 Mandatory social work amounts and availability**

- (a) The facility shall provide an average of at least 20 minutes of social work services per week for each resident, which requires at least one full-time equivalent social worker for every 120 residents.
- (b) A social worker shall assist staff in coping with the personal needs and demands of particular residents.

**§ 8:39-39.4 Mandatory resident social work services**

- (a) A social worker shall interview the resident and family within 14 days before or after admission to the facility to identify any social work needs or problems, and to take a social history that includes family, education, and occupational background, adjustment and level of functioning, interests, support systems, and observations.
- (b) A social worker shall provide counseling for residents and families.
- (c) A social worker shall facilitate communication between staff and non-English speaking residents.
- (d) A social worker shall offer information and help to each resident and family on obtaining financial assistance and on the meaning of administrative forms and releases to be signed by the resident or family.
- (e) A social worker shall coordinate the facility's outreach services to the families of residents.
- (f) A social worker shall coordinate discharge services for residents, which shall include linking the resident to necessary community services .
- (g) A social worker shall perform advocacy services on behalf of the residents to ensure that concrete needs are met, such as clothing, laundry, and the resident's personal needs allowance if one is maintained.
- (h) A social worker shall help residents and families identify and gain access to community services, using resource materials and a knowledge of the residents' needs and abilities.
- (i) The facility shall provide clinical social work services to residents as needed and to families if related to issues that directly affect the resident.

**§ 8:39-39.5 Mandatory space and environment for social work**

The facility shall provide visual and auditory privacy for resident or family social service interviews, and for confidential telephone calls by social workers.



## **SUBCHAPTER 40. ADVISORY SOCIAL WORK**

### **§ 8:39-40.1 Advisory staff qualifications for social work**

A social worker has a master's degree in social work from an accredited university or education program. He or she should provide consultant services at least eight hours per month, or be on the facility's staff.

### **§ 8:39-40.2 Advisory staff amounts and availability for social work**

- (a) A social worker is available to the facility on evenings and weekends at scheduled times or by previously arranged appointments for interaction with residents and families, and is available seven days a week in cases of emergency or serious need.
- (b) A social worker assists staff with problems and issues related to aging and illness.
- (c) A social worker orients nurse aides to the social needs of new residents before the resident's arrival in the facility.

### **§ 8:39-40.3 Advisory resident social work services**

- (a) A social worker meets with the resident on the day of admission.
- (b) A social worker conducts support groups for families.
- (c) A social worker conducts group counseling sessions for residents and families.
- (d) A social worker participates in pre-admission planning with residents and families prior to their admission to the nursing home.
- (e) The social worker encourages and monitors a regular visiting pattern by families and provides outreach services to families where the visiting pattern has changed.

### **§ 8:39-40.4 Advisory space and environment for social work**

Social workers are to be provided with a private office equipped with a telephone or, in facilities with 60 or fewer licensed beds, with access to a private office equipped with a telephone.

### **§ 8:39-40.5 Advisory social work staff education and training**

The facility encourages the social worker to participate in community agency associations and other professional organizations.

## **SUBCHAPTER 41. MANDATORY STAFF POSTING AND REPORTING STANDARDS**

### **§ 8:39-41.1 Authority and purpose**

- (a) The Commissioner of the Department of Health and Senior Services promulgates this subchapter pursuant to the authority of N.J.S.A. 26:2H-1 et seq., particularly N.J.S.A. 26:2H-5h.
- (b) The purpose of this subchapter is to provide residents, their families and the public information as to the extent of direct resident care staffing levels provided by long-term care facilities; establish requirements for long-term care facilities to post, on a shift-by-shift basis, information about direct resident care staffing levels in a visible

and accessible location; and establish procedures for long-term care facilities to report aggregated data to the Department on a monthly basis.

### § 8:39-41.2 Information required to be posted; retention

- (a) A facility shall post the direct resident care staffing information described in (c) below, utilizing the Resident Care Staffing Report, incorporated herein by reference and set forth at chapter Appendix G, prior to the start of the shift for which information is being reported in a visible location in the facility that is accessible to residents, their families, members of the public and caregivers.
- (b) A facility shall post the direct resident care staffing information required by 42 CFR 483.30(e), incorporated herein by reference, as amended and supplemented, on the Resident Care Staffing Report.
- (c) Each facility shall collect the following information for each shift in the facility:
  1. Resident census at the start of the shift for which information is being reported;
  2. The hours each registered nurse, licensed practical nurse and/or certified nurse aide responsible for direct resident care is scheduled to work on the shift for which information is being reported;
  3. Number of staff; and
  4. The staff-to-resident ratio.
- (d) Each facility shall post changes in the information reported on the Resident Care Staffing Report resulting from staff absences or the addition of staff within two hours of the facility's notation of such changes.
- (e) The Resident Care Staffing Report form is available through the following methods:
  1. Electronically at the Department's "Forms" webpage at <http://web.doh.state.nj.us/apps2/forms/>;
  2. Electronically at the Certificate of Need and Healthcare Facility Licensure Program's webpage at <http://nj.gov/health/healthfacilities/forms.shtml>; and
  3. Upon written request to:  
Director  
Certificate of Need and Healthcare Facility Licensure Program  
New Jersey Department of Health and Senior Services  
PO Box 358  
Trenton, New Jersey 08625-0358
- (f) If a language other than English is the exclusive language spoken by at least 10 percent of a facility's residents, the facility shall translate the Resident Care Staffing Report into that language and post the forms both in English and the other language.
- (g) All facilities shall establish procedures to provide a copy of the completed Resident Care Staffing Report at no charge to any member of the public upon request.
- (h) Each facility shall retain and store the completed daily Resident Care Staffing Reports for a period of three years.

### § 8:39-41.3 Reporting requirements

- (a) Each long-term care facility shall report the following information to the Department once a month on a web-based interface to be developed and communicated by the

Department, which shall include the use of the information already collected on the Resident Care Staffing Report, as set forth as chapter Appendix G:

1. Broken down by shift, the average of the previous month's daily ratios of staff-to-residents for each category of direct resident care staff.
- (b) The public may obtain the quarterly report, which the Department is required to complete pursuant to N.J.S.A. 26:2H-5g(d), through the following methods:
1. Electronically at the Certificate of Need and Healthcare Licensure Program's webpage at [www.nj.gov/health/healthcarequality](http://www.nj.gov/health/healthcarequality); and
  2. Upon written request to:  
Director  
Certificate of Need and Healthcare Facility Licensure Program  
New Jersey Department of Health and Senior Services  
PO Box 358  
Trenton, New Jersey 08625-0358

#### **§ 8:39-41.4 Penalty**

If the Commissioner determines that a facility has violated any provision of this subchapter, the Department may issue an enforcement action pursuant to P.L. 2005, c. 21, § 2(e), N.J.S.A. 26:2H-5g(e), and N.J.A.C. 8:43E-3

### **SUBCHAPTER 42. (RESERVED)**

#### **§ 8:39-42 (RESERVED)**

### **SUBCHAPTER 43. CERTIFICATION OF NURSE AIDES IN LONG-TERM CARE FACILITIES**

#### **§ 8:39-43.1 Nurse aide competency**

- (a) An individual who meets any of the following criteria shall be considered by the Department to be competent to work as a nurse aide in a licensed long-term care facility in New Jersey:
1. Has a currently valid nurse aide in long-term care facilities certificate and is registered in good standing on the New Jersey Nurse Aide Registry;
  2. Has been employed for less than 120 days and is currently enrolled in an approved nurse aide in long term care facilities training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within 120 days of employment; or
  3. Has been employed for no more than 120 days, has completed the required training specified in (a)2 above, and has been granted a conditional certificate by the Department while awaiting clearance from the criminal background investigation conducted in accordance with N.J.A.C. 8:43I.

#### **§ 8:39-43.2 Requirements for nurse aide certification**

- (a) An applicant for certification as a nurse aide in long-term care facilities shall:
1. Successfully complete a nurse aide in long-term care facilities training program that has been approved by the Department;

2. Provide evidence that he or she is of good moral character, including, but not limited to, compliance with the requirements of the Criminal Background Investigation Program in accordance with N.J.A.C. 8:43I; and
  3. Pass both the Department's clinical skills competency exam and written/oral exam.
- (b) An applicant shall fulfill the requirements in (a) above in order to be listed on the New Jersey Nurse Aide Registry.

### **§ 8:39-43.3 Exceptions**

- (a) The following persons may take the Department's written/oral examination without first completing a nurse aide training course and clinical skills evaluation approved in accordance with N.J.A.C. 8:39-43.10:
1. Students, graduate nurses, or foreign licensed nurses, pending licensure, who submit evidence of successful completion of a course in the fundamentals of nursing;
  2. Persons who submit evidence of the successful completion of a course in the fundamentals of nursing within the 12 months immediately preceding application to take the written/oral competency examination, including:
    - i. Persons certified as a nurse aide in long-term care facilities in another state by a state governmental agency and listed on that state's nurse aide registry, who do not meet the requirements for equivalency specified at (a)1 above; and
    - ii. Persons who have had training and experience as a nurse aide in a military service, equivalent to that of a nurse aide;
  3. Persons who are certified as homemaker-home health aides by the New Jersey Board of Nursing, in accordance with N.J.A.C. 13:37-14, and who successfully complete the Long-Term Care Module of the Core Curriculum for Unlicensed Assistive Personnel approved by the Department; and
  4. Persons who successfully complete the Core Curriculum for Unlicensed Assistive Personnel approved by the Department and the New Jersey Board of Nursing, and the Long-Term Care Module of the Core Curriculum for Unlicensed Assistive Personnel approved by the Department.

### **§ 8:39-43.4 Certificates**

- (a) A nurse aide in long-term care facilities certificate shall be valid for a period of two years from the date of issue.
- (b) A nurse aide certificate shall not be retained by an employer for any reason.
- (c) A nurse aide certificate is not transferable by sale, gift, duplication, or other means and shall not be forged or altered

### **§ 8:39-43.5 Revocation and suspension of certificates**

- (a) A certificate issued to a nurse aide in accordance with this subchapter shall be revoked in the following cases:
1. Finding of abuse, neglect or misappropriation of property of a resident of a long-term care facility or assisted living residence, or of a patient, resident, or client of any other facility or agency licensed by the Department;

2. Conviction or guilty plea as specified at N.J.A.C. 8:39-9.3(b) or other crime or offense as specified at N.J.A.C. 8:43I-2.1(b); or
  3. Sale, purchase, or alteration of a certificate; use of fraudulent means to secure the certificate, including filing false information on the application; or forgery, imposture, dishonesty, or cheating on an examination.
- (b) The Commissioner or his or her designee may summarily suspend the certificate of a nurse aide when the continued certification of an individual poses an immediate threat to the health, safety or welfare of the public, including residents and patients of long-term care facilities, assisted living facilities and other licensed health care facilities or agencies. An individual whose certificate is summarily suspended shall have the right to appeal to the Commissioner for an expedited hearing at the Office of Administrative Law, which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and N.J.S.A. 52:14F-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1. If the summary suspension is upheld at the Office of Administrative Law, the individual whose certificate has been summarily suspended shall have the right to apply for injunctive relief in the Superior Court of New Jersey. Nothing in this subsection shall be construed to prevent the Commissioner from thereafter revoking the license in accordance with (a) above.

## CASE NOTES

Initial Decision (2009 N.J. AGEN LEXIS 586) adopted, which found that a certified nurse aide verbally and mentally abused a resident by yelling and cursing at the resident in response to the resident's provocative agitated behavior after the aide took a cup of coffee from her that belonged to another resident; provocation was not a defense where the aide was trained to handle an agitated patient with restraint. N.J. Dep't of Health & Senior Services v. Easterling-Leake, OAL Dkt. No. HLT 03649-2009 N, 2009 N.J. AGEN LEXIS 756, Final Decision (September 28, 2009).

Initial Decision (2009 N.J. AGEN LEXIS 302) adopted, in which the ALJ found, on conflicting evidence, that a nurse aide misappropriated and used the credit cards of resident patients in her care; the aide's contention that she was framed by the real perpetrator was not supported by the overwhelming circumstantial evidence against her. N.J. Dep't of Health & Senior Services v. Lee, OAL Dkt. No. HLT 01070-09, 2009 N.J. AGEN LEXIS 570, Final Decision (June 18, 2009).

ALJ erred in sanctioning a nurse aide to a 5-day suspension of her certificate where no such sanction existed; rather the applicable sanction for a finding of neglect was placement on the nurse aide registry for a period of at least one year, and full revocation was required in the case of a finding of abuse, neglect or misappropriation of resident property. The Commission overturned the negligence finding and the 5-day suspension and ordered the case remanded so that the ALJ could apply the proper standard of review, review the testimony regarding the allegations of verbal abuse, and impose an appropriate sanction. N.J. Dep't of Health & Senior Services v. Rogers, OAL Dkt. No. HLT 1006-08, 2009 N.J. AGEN LEXIS 660, Final Decision/Remand Order (March 26, 2009).

Initial Decision (2009 N.J. AGEN LEXIS 141) adopted, in which the ALJ found, on conflicting testimony, that a nurse aide physically abused a resident when she struck back at the resident who had hit her during a diaper change; the fact that the incident occurred during the aide's probationary employment period rendered the conduct that much more egregious, and her projected conduct once she acquired permanent employment did not bode well for her residents. N.J. Dep't of Health & Senior Services v. Boatwright, OAL Dkt. No. HLT 10269-08, 2009 N.J. AGEN LEXIS 666, Final Decision (March 25, 2009).

Initial Decision (2009 N.J. AGEN LEXIS 140) adopted, which found that a nurse aide misappropriated resident property when she used a resident's ATM card without his authorization to withdraw \$ 7,602.38 over a three month period for her own benefit; the aide's contention that the withdrawals were favors to the resident, who wanted to buy snacks and re-pay debts he owed to others, was simply not credible nor supported by the evidence. Huber v. N.J. Dep't of Health & Senior Services, OAL Dkt. No. HLT 09286-08, 2009 N.J. AGEN LEXIS 665, Final Decision (March 9, 2009).

Nurse aide's certification was revoked for one year and an entry on the Nurse Aide Registry was ordered for a period of one year, where the aide was properly charged with neglect because she failed to use a Hoyer lift rather than a one-man lift to lift a resident, who had suffered a stroke that left her

with limited mobility. The aide was further properly charged with neglect because once the resident fell, the aide failed to provide her charge nurse with the information as to what had occurred so that the resident could be properly treated. N.J. Dep't of Health & Senior Services v. Cator, OAL Dkt. No. HLT 8230-07, 2008 N.J. AGEN LEXIS 179, Initial Decision (March 8, 2008).

Certified nurse aide's act of throwing a balled-up sheet at a resident of a long-term care facility and spinning the resident around in her wheelchair constituted abuse. N.J. Dep't of Health & Senior Services v. Jean, OAL Dkt. No. HLT 10885-06, 2007 N.J. AGEN LEXIS 419, Initial Decision (June 7, 2007).

Nurse aide's name was to be listed on the Nurse Aid Registry and her certificate revoked, where evidence showed that (1) while being showered, a resident asked repeatedly to use the bathroom, but the aide refused to allow her to do so despite being in immediate proximity to a facility and instead, the aide required the resident to void into a plastic garbage bag, causing the resident to experience embarrassment and mental distress; (2) the aide jammed the shower wand between the resident's legs and moved it back and forth, causing injury to the resident's labia in the form of abrasions resulting in harm, pain, and mental anguish; and (3) the aide left the resident in her room covered only by a sheet and when the sheet fell off, the resident was exposed to the view of workmen and others in the hall, causing the resident to be denied privacy and to experience embarrassment and mental anguish. N.J. Dep't of Health & Senior Services v. Badio, OAL Dkt. No. HLT 9591-06, 2007 N.J. AGEN LEXIS 41, Initial Decision (January 22, 2007).

Ordering revocation of a nurse aide's certification and permanent placement of her name on the Nurse Aide Registry, where credible evidence supported the finding that the aide struck the resident with a shoe after the resident kicked the aide in the stomach when the resident did not want to get out of bed, and the aide's action caused swelling and a large bruise. N.J. Dep't of Health & Senior Services v. Lacrete, OAL Dkt. No. HLT 7560-04, 2006 N.J. AGEN LEXIS 818, Initial Decision (September 26, 2006).

Adopting Initial Decision (2005 N.J. AGEN LEXIS 568) and ordering that a finding of misappropriation of a resident's property be placed next to a nursing aide's name on the Nurse Aide Registry and her certificate revoked, where evidence showed that the aide took the checkbook of a former resident of a specialty care center to the aide's home, and failed to report the taking to the resident, to the center, or to the police. N.J. Dep't of Health & Senior Services v. Williams, OAL Dkt. No. HLT 8937-04, 2005 N.J. AGEN LEXIS 1315, Final Decision (November 1, 2005).

Initial Decision (2005 N.J. AGEN LEXIS 642) adopted, which found that a nurse aide did not act with malice in blocking a patient's access to the elevator, but rather, was trying to protect the resident from harm, and that the nurse aide merely acted in self-defense when she grabbed the resident's arm after the resident was pulling the aide's hair; thus, the nurse aide did not commit abuse. "Abuse" cannot involve conduct that is simply accidental or inadvertent. Dep't of Health & Senior Services v. Jarda, OAL Dkt. No. HLT 11114-04, 2005 N.J. AGEN LEXIS 1309, Final Decision (October 20, 2005).

### § 8:39-43.6 Recertification

- (a) The Department shall require the renewal and updating of a nurse aide listing on the registry at least once every two years on a schedule established by the Department.
- (b) In order to be recertified, an individual shall have a currently valid nurse aide in long-term care facilities certificate and shall have been employed performing nursing or nursing-related services for at least seven hours for pay, in a licensed health care facility or for an agency licensed by the Department, within the past 24 months from the date of expiration as specified on the nurse aide certificate, and shall not have had his or her certificate revoked in accordance with N.J.A.C. 8:39-43.5(a), and shall not have his or her certificate suspended in accordance with N.J.A.C. 8:39-43.5(b).
- (c) The designated facility representative shall verify such employment by signing the individual's recertification data mailer upon request of the individual.
- (d) Any individual who does not meet the recertification requirement listed in (b) above and who wishes to be recertified, shall repeat the requirements for certification at N.J.A.C. 8:39-43.2, unless the original date of issue of the certificate is within the five years prior to the expiration date listed on the certificate and the nurse aide successfully completes the skills evaluation and written/oral examination.

1. Any individual who has allowed his or her certificate to expire must undergo a criminal background investigation as required by N.J.A.C. 8:43I, regardless of whether the person must complete a training program.

### § 8:39-43.7 Nurse aide registries

- (a) The Department shall establish and maintain a nurse aide registry in accordance with 42 CFR 483.156, as supplemented and amended.
- (b) The Department shall establish and maintain a nurse aide abuse registry in accordance with 42 CFR 483.156, as supplemented and amended.
  1. The nurse aide abuse registry shall include the names of individuals who are found to have abused, neglected or misappropriated the property of any resident while working in a long-term care facility as an uncertified nurse aide.

### CASE NOTES

Adopting Initial Decision (2007 N.J. AGEN LEXIS 813) and ordering that a finding of neglect be entered on the Nurse Aide Registry, where although the certified nurse aide's testimony claiming her innocence of the charge appeared to be credible based upon her demeanor, the testimony of other witnesses and the objective physical evidence preponderated in favor of a finding of guilt. It was indisputable that the aide was responsible for the care of an elderly, incontinent resident, that the resident got out of her bed and her doing so was not detected because the tabs monitor was not attached as required by the Kardex care plan, that the resident's diaper and clothing were soaked with urine and soiled with feces, that the resident suffered a serious injury to her left hip and leg, and that the aide admitted to the risk manager at the care center and to the director of nursing that she had not examined or checked the resident from approximately 1:30 a.m. until she was found at approximately 5:30 a.m. in contravention of the aide's responsibility to toilet the resident every two hours. N.J. Dep't of Health & Senior Services v. Pawlowska, OAL Dkt. No. HLT 6659-07, 2008 N.J. AGEN LEXIS 146, Final Decision (January 18, 2008).

Initial Decision (2007 N.J. AGEN LEXIS 787) adopted, which concluded that the evidence was insufficient to warrant placing a certified nurse aide on the Nurse Aide Registry for allegedly having verbally abused a resident under her care. N.J. Dep't of Health & Senior Services v. Lewis, OAL Dkt. No. HLT 7747-07, 2008 N.J. AGEN LEXIS 147, Final Decision (January 18, 2008).

Certified nurse aide committed an act of abuse when a resident was splashed with hot tea; despite the aide's claim that warm tea was accidentally spilled, witnesses who were actually present in the room when the incident occurred agreed that the resident was becoming agitated and further agreed that the aide did have a cup of hot tea in her hand and did throw the hot tea at the resident in response to the resident's agitation, and an examination of the resident shortly after the incident showed that the resident's chest was red from the tea (adopting in part and modifying in part 2007 N.J. AGEN LEXIS 788). N.J. Dep't of Health & Senior Services v. Snowden, OAL Dkt. No. HLT 7842-07, 2008 N.J. AGEN LEXIS 148, Final Decision (January 18, 2008).

Initial Decision (2007 N.J. AGEN LEXIS 487) adopted, which concluded that a certified nurse aide neglected and abused a resident in a long-term care facility where the resident, an alert and oriented woman, testified that the aide had hit her face on the left side rail of the bed as she was helping the resident during the night; the resident further testified that when the resident told the aide what she, the aide, had done, the aide responded "good" and advised her to shut up, the resident was not changed until 2:00 a.m. that morning, and that was all the assistance and care that she had received for that night shift. N.J. Dep't of Health & Senior Services v. Adams, OAL Dkt. No. HLT 3783-07, 2007 N.J. AGEN LEXIS 929, Final Decision (August 20, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 487) adopted, which concluded that a certified nurse aide neglected a resident in a long-term care facility where the resident, who could not toilet herself at the time in question, testified that she could not move fast enough when she was turning over on her left side during the night and the aide was rough in turning her, that she thereafter tried to help herself and called for help, that she could not remember how long she waited for help before she took her diaper off and threw it on the floor, and that the aide had told her she would be back to change her in

a short time but the aide never returned to change her. N.J. Dep't of Health & Senior Services v. Adams, OAL Dkt. No. HLT 3783-07, 2007 N.J. AGEN LEXIS 929, Final Decision (August 20, 2007).

Adopting Initial Decision (2007 N.J. AGEN LEXIS 453) and ordering that a finding of verbal abuse be entered on the Nurse Aide Registry, where credible evidence established that a patient approached the aide and several other aides and interrupted their conversation, that as a result of this interruption, the aide told the patient that no one was talking to her and that, because of similar prior conduct of the patient, "That's why my mother is alive and . . . your mother is dead," and the aide's remark upset the resident to an extent not seen previously. N.J. Dep't of Health & Senior Services v. Jenkins, OAL Dkt. No. HLT 4964-06, 2007 N.J. AGEN LEXIS 930, Final Decision (August 9, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 452) adopted, which found, on conflicting evidence, that a certified nurse aide transferred a stroke victim resident from the resident's wheelchair to the bed in a rough manner, pulled on the resident's paralyzed arm, thereby causing the resident pain, failed to communicate with the resident upon the resident's expression of pain, and threw a towel at the resident, and concluded that these acts did not rise to the level of abuse, but did constitute neglect, justifying an entry on the Nurse Aide Registry. N.J. Dep't of Health & Senior Services v. Armand, OAL Dkt. No. HLT 1343-07, 2007 N.J. AGEN LEXIS 966, Final Decision (August 9, 2007).

Adopting Initial Decision (2007 N.J. AGEN LEXIS 418) and ordering that a finding of misappropriation of a resident's property be placed on the Nurse Aide Registry, where it appeared that a certified nurse aide used the telephone of a long-term care facility resident on several occasions. Although the aide raised her absence of understanding, and therefore requisite intent, it was not believable to argue in her defense that a long-experienced certified nursing aide, over the course of three separate days, could have made calls in all innocence from a phone she knew to have been paid for by a resident, and in reliance on the ostensible permission allowed by the same resident, who was suffering from partial dementia. N.J. Dep't of Health & Senior Services v. Robert, OAL Dkt. No. HLT 803-07, 2007 N.J. AGEN LEXIS 931, Final Decision (July 18, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 185) adopted, which concluded that a finding that a certified nurse aide verbally abused a resident had been substantiated and should be entered on the Nurse Aide Registry where it appeared that the aide did threaten and curse at the resident, pointing a can of deodorant in his face; in addition, the aide engaged the resident in verbal disputes, and allowed the matter to escalate instead of diffusing the situation. N.J. Dep't of Health & Senior Services v. Thompson, OAL Dkt. No. HLT 249-07, 2007 N.J. AGEN LEXIS 542, Final Decision (May 17, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 154) adopted, which concluded that a certified nurse aide neglected a resident in a long-term care facility where the aide, faced with a situation of a resident who was incontinent, upset, and in need of a clothing change and careful attention, simply left the resident alone in his room, slumped over in his chair, seated in feces, vulnerable to the anxiety-inducing turmoil she created, and then left the facility without completing her shift, although she had been promised that another aide would be available to help within only a few minutes of her request for aid. N.J. Dep't of Health & Senior Services v. Martinez, OAL Dkt. No. HLT 320-07, 2007 N.J. AGEN LEXIS 526, Final Decision (May 14, 2007).

Adopting Initial Decision's conclusion that neither a finding of neglect nor a finding of abuse should be placed next to the nurse aide's name on the Nurse Aide Registry for alleged abuse and neglect of an elderly resident suffering from Alzheimer's Disease; the ALJ found that the testimony of the resident's roommate was unreliable and not credible, and the director of social services at the facility and a certified nurse's aide both disbelieved the roommate's statements on the matter. N.J. Dep't of Health & Senior Services v. Yates, OAL Dkt. No. HLT 8438-06, 2007 N.J. AGEN LEXIS 326, Final Decision (March 15, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 29) accepted, which concluded that a certified nurse aide did not neglect or verbally or mentally abuse two residents of an assisted living and convalescent home by statements that the two residents did not like black people; while an incident occurred involving the two residents and the aide in the dining room that, at the minimum, had the aide speaking in a loud and/or gruff manner as concerns the topic of who would be caring for the residents while their white aide was on vacation, the aide in no way intended for her statement to be intimidating or otherwise to cause pain or mental anguish, humiliation, or harassment. N.J. Dep't of Health & Senior Services v. McIntosh, OAL Dkt. No. HLT 212-07, 2007 N.J. AGEN LEXIS 324, Final Decision (March 8, 2007).

Adopting Initial Decision (2007 N.J. AGEN LEXIS 5) and ordering that a finding of abuse be entered on the Nurse Aide Registry, where the eyewitness's statement was consistent with photographs showing



the patient's bruise marks; the certified nurse aide, who had denied the allegation, did not appear at the hearing. N.J. Dep't of Health & Senior Services v. Francois, OAL Dkt. No. HLT 11769-05, 2007 N.J. AGEN LEXIS 323, Final Decision (February 22, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 19) adopted, which concluded that DHSS carried its burden of persuasion of proof by a preponderance of the competent and credible evidence that two nurse aides abused a resident and that their names should be placed in the Nurse Aide Registry; the aides' explanations about the clearly abusive comments and restriction of the resident to her room lacked credibility, and neither could offer an explanation regarding their instances of swearing as to why they believed the resident should learn to be a better cursor. N.J. Dep't of Health & Senior Services v. Williams, OAL Dkt. No. HLT 8404-04 and HLT 8842-04, 2007 N.J. AGEN LEXIS 325, Final Decision (February 22, 2007).

Initial Decision (2006 N.J. AGEN LEXIS 724) adopted, which concluded that DHSS had failed to prove by a preponderance of the credible evidence that two certified nurse aides abused or were negligent in their handling of their patient, an older woman, who was demented, easily confused, and at risk of falling and who had fallen from a chair and fractured her hip; no injury report was submitted, no one saw the patient fall, no one clearly stated that there was no safety belt, no physician's orders were introduced, and no management safety plan for the patient was introduced. N.J. Dep't of Health & Senior Services v. Yu, OAL Dkt. No. HLT 429-06; HLT 2392-06, 2006 N.J. AGEN LEXIS 873, Final Decision (September 27, 2006).

Initial Decision (2006 N.J. AGEN LEXIS 725) adopted, which concluded that it could not be found that a certified nurse aide threw a wet pad at a resident of a long-term care facility where there was no competent legal evidence to corroborate the resident's hearsay statement that the act had occurred. N.J. Dep't of Health & Senior Services v. Turner, OAL Dkt. No. HLT 2091-06, 2006 N.J. AGEN LEXIS 872, Final Decision (September 20, 2006).

Initial Decision (2006 N.J. AGEN LEXIS 454) adopted, which concluded that the evidence was insufficient to support a finding of neglect by a certified nurse aide; the ALJ found that DHSS did not show that the aide intentionally moved the call bell out of the patient's reach, where the aide's testimony was sufficiently credible that she tied the call bell to the side of the bed to prevent harm to the patient after the patient had previously wrapped it around his neck, and the bell inadvertently fell to the ground. N.J. Dep't of Health & Senior Services v. Toth, OAL Dkt. No. HLT 2106-06, 2006 N.J. AGEN LEXIS 782, Final Decision (August 25, 2006).

Name of a certified nurse aide would not be placed on the Nurse Aide Registry on grounds that the aide struck and/or taunted a resident, where the resident clearly had no recollection of what had occurred, her testimony was rambling, incoherent, and not believable, her statements taken after the incident were inconsistent, including the failure to tell a nurse that the aide had struck her, and there was the absence of any red marks or bruises; on the other hand, the aide appeared very soft spoken and was consistent in her testimony. N.J. Dep't of Health & Senior Services v. Toussaint, OAL Dkt. No. HLT 755-06, 2006 N.J. AGEN LEXIS 453, Initial Decision (July 19, 2006).

Initial Decision (2006 N.J. AGEN LEXIS 336) adopted, which concluded that neglect of a resident by a certified nurse aide had not been substantiated; although it was undisputed that the physician had ordered the use of a Gerrichair with a lap tray to keep resident, a fall risk, in a seated position and that the resident had been placed in a Gerrichair with no tray and with no tab alarm to sound if the resident attempted to rise, the aide's testimony about the lack of notice and knowledge as to the resident's care plan was entirely credible based on the observations of the aide and her demeanor during her testimony as well as the fact that even the nursing staff and the direct care staff on an earlier shift were unaware of the safety precautions applicable to the resident. N.J. Dep't of Health & Senior Services v. Quirindongo, OAL Dkt. No. HLT 754-06, 2006 N.J. AGEN LEXIS 584, Final Decision (June 16, 2006).

Adopting Initial Decision (2005 N.J. AGEN LEXIS 959) and ordering that a finding of abuse be entered on the Nurse Aide Registry, where the ALJ found sufficient credible evidence of the aide's verbal and physical abuse of patients, including yelling at a patient and placing a pillow-case over a patient's head. N.J. Dep't of Health & Senior Services v. Casey, OAL Dkt. No. HLT 01890-05, 2005 N.J. AGEN LEXIS 1306, Final Decision (December 6, 2005).

Adopting Initial Decision (2005 N.J. AGEN LEXIS 568) and ordering that a finding of misappropriation of a resident's property be placed next to a nurse aide's name on the Nurse Aide Registry and the aide's certificate revoked, where evidence showed that the aide took the checkbook of a former resident of a

specialty care center to the aide's home, and failed to report the taking to the resident, to the center, or to the police. N.J. Dep't of Health & Senior Services v. Williams, OAL Dkt. No. HLT 8937-04, 2005 N.J. AGEN LEXIS 1315, Final Decision (November 1, 2005).

Initial Decision (2005 N.J. AGEN LEXIS 494) adopted, which concluded that DHSS had not shown abuse by a preponderance of evidence, where none of the eyewitnesses could testify that the certified nurse aide purposely hit an Alzheimer's resident with her arm or elbow when the aide was attempting to close the dining room doors; in addition, although voices were raised, there was no evidence that the aide engaged in the willful use of oral or gestured language that in any way included disparaging and derogatory terms directed at the resident. N.J. Dep't of Health & Senior Services v. Smith, OAL Dkt. No. HLT 1220-05, 2005 N.J. AGEN LEXIS 1310, Final Decision (October 24, 2005).

Adopting Initial Decision (2005 N.J. AGEN LEXIS 358) and ordering that a finding of abuse be entered on the Nurse Aide Registry where the evidence showed that a certified nurse aide abused a quadriplegic resident in her early 60's, suffering from MS and with very slight use of her hands, by comments that subjected the resident to mental anguish, disparaging and derogatory terms within the resident's hearing, and threats of deprivation and involuntary seclusion. In particular, the aide, in the presence and hearing of the resident, stated to two students training to become certified nurse aides that the resident was "too heavy" and "dead weight," the aide told the resident to "lay off the call light" because she was not going to return to get her up again, and when informed by the resident that she had the flu, the aide harshly retorted that the flu had nothing to do with her "acting up" and again told her not to use the call light. N.J. Dep't of Health & Senior Services v. Michael-George, OAL Dkt. No. HLT 6685-04, 2005 N.J. AGEN LEXIS 1472, Final Decision (September 16, 2005).

Initial Decision (2005 N.J. AGEN LEXIS 391) adopted, finding that there was sufficient credible evidence to support the agency's claim that a certified nurse aide abused and neglected a nursing home resident by placing the call bell out of the resident's reach. N.J. Dep't of Health & Senior Services v. Wilson, OAL Dkt. No. HLT 2100-05, 2005 N.J. AGEN LEXIS 1110, Final Decision (September 9, 2005).

### **§ 8:39-43.8 Hearings for resident abuse, resident neglect, or misappropriation of resident property**

- (a) Prior to entering a finding on the nurse aide abuse registry, the Department shall provide an opportunity of at least 30 days notice to the certified nurse aide or uncertified nurse aide, identifying the intended action, the factual basis and source of the finding, and the individual's right to a hearing.
- (b) If a hearing is requested, it shall be conducted by the Office of Administrative Law or by a hearing officer of the Department in accordance with hearing procedures established by the Administrative Procedure Act., N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq. and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.
- (c) No further right to an administrative hearing shall be offered to a certified nurse aide or uncertified nurse aide who has been afforded a hearing before a State or local administrative agency or other neutral party, or in a court of law, at which time the nurse aide received adequate notice and an opportunity to testify and to confront witnesses, and where there was an impartial hearing officer who issued a written decision verifying the findings of abuse, neglect, or misappropriation of property of a resident. The individual shall have a right to enter a statement to be included in the registry contesting such findings.

### **§ 8:39-43.9 Equivalency for nurse aides registered in other states**

- (a) A nurse aide certificate received in another state or territory of the United States may be entered on the registry, provided that the following conditions are satisfied:
  1. The Department receives documentation from the state's or U.S. territory's registry that such nurse aide has completed a training and competency evaluation program at least equal to that required in New Jersey;

2. The nurse aide has not been convicted of any crimes and has no documented findings of abuse, neglect, or misappropriation of resident property on the registry; and
3. The nurse aide complies with the requirements for a criminal background investigation as required by N.J.A.C. 8:43I.

### **§ 8:39-43.10 Approval of a nurse aide in long-term care facilities training program**

- (a) Written approval of the Department is required prior to enrollment of students and the commencement of a training program in an educational institution, a facility, or a proprietary program. Training program approval, when granted, shall be granted for a 24-month period.
- (b) An approved training program for nurse aides shall consist of 90 hours of training. This shall include 50 hours of classroom instruction and 40 hours of clinical experience in a New Jersey licensed long-term care facility. All training programs shall use the curriculum approved by the Department, in accordance with (c) below.
- (c) The New Jersey Curriculum for Nurse Aide Personnel in Long-Term Care Facilities ("the curriculum"), which has been approved by the Department, shall be the approved curriculum for a 90 hour training program. The entire content of the curriculum shall be taught. A copy of the curriculum and the form needed to apply for approval of a training course may be obtained by contacting the following office:
- (d) The New Jersey competency evaluation shall consist of both a skills examination and a written/oral examination.
- (e) A facility-based approved training program and the New Jersey competency evaluation shall be scheduled so as to be completed within 120 days of the starting date of employment for a nurse aide.
- (f) A training program offered in an educational institution to train and test certified nurse aides shall be approved by the Department.
- (g) No resident care unit shall serve as the site of clinical instruction for more than one training program at a time.
- (h) The training program for nurse aides shall not be used as a substitute for staff orientation or staff education programs.
- (i) Classroom and clinical instruction for particular tasks or procedures shall be scheduled concurrently to the extent practicable.
- (j) The Department may request submission of additional information or require the redesign and/or revision of the program materials. Redesign or revision of the program application does not ensure that approval will be granted.
- (k) Any changes in a training program, such as changes in location, dates, times or instructors, shall be reported in writing, to the Certification Program at least 30 working days prior to the planned change. No change shall be implemented without the written approval of the Certification Program.
- (l) The facility or educational institution conducting a training program shall maintain on file a copy of the lesson plans for the course. Each lesson plan shall state, at a minimum, the following:
- (m) Each nurse aide training program instructor/evaluator shall:

- (n) The student-to-instructor ratio for classroom instruction shall not exceed a ratio of 20 students to one instructor.
- (o) The student-to-instructor ratio for clinical instruction shall not exceed a ratio of 10 students to one instructor.
- (p) Each student shall be under the supervision of the registered professional nurse instructor at all times when providing resident care as part of the student's clinical experience in the facility. The registered professional nurse instructor shall be responsible for evaluating the student's classroom and clinical performance.
- (q) The resume of each nurse instructor/evaluator currently teaching the training program shall be available in the facility or educational institution.

### **§ 8:39-43.11 Evaluation of training programs**

- (a) The facility or educational institution conducting a training program shall develop, implement, and document a process for evaluating the effectiveness of the training program. The evaluation process shall include, at a minimum, the following:
  - 1. Assignment of responsibility for the evaluation process;
  - 2. An annual written evaluation report, including findings, conclusions, and recommendations;
  - 3. A written evaluation by the facility or educational institution of the performance of instructors/evaluators;
  - 4. Written evaluations, by students, of the training program; and
  - 5. Statistical data that shall be maintained on file in the facility or educational institution. The statistical data shall include, at a minimum, the following for each course:
    - i. The beginning and ending dates;
    - ii. The number of students enrolled;
    - iii. The number and percentage of students who satisfactorily completed the course;
    - iv. The number and percentage of students who failed the course;
    - v. The number and percentage of students who passed the New Jersey Nurse Aide Competency Evaluation Program, including written/oral examination and skills; and
    - vi. The number and percentage of students who failed the New Jersey Nurse Aide Competency Evaluation Program, including written/oral examination and skills.
- (b) The facility or training program shall retain all evaluation reports for at least three years and shall submit a report to the Department upon request.

### **§ 8:39-43.12 Student records**

- (a) Each facility or educational institution that conducts a training program shall establish a student record for each student. The student record shall include, at a minimum, the following:
  - 1. The beginning and ending dates of the training program;
  - 2. An attendance record;

3. A signed skills competency task form; and
  4. An evaluation of the student's classroom and clinical performance, completed by the student's instructor.
- (b) The facility shall retain the records specified at (a) above for at least four years.
- (c) The facility or educational institution conducting a training program shall ensure that a student who is absent receives a reasonable and timely opportunity to obtain the classroom and/or clinical instruction missed, as documented in the student's record.

**§ 8:39-43.13 Denial or termination of a nurse aide in long-term care facilities training program**

- (a) The Department shall conduct unannounced site visits of a nurse aide in long-term care facilities training program.
- (b) The Department may deny, suspend, or withdraw approval if it determines that a nurse aide training program fails to follow the application as submitted to, and approved by, the Department.
- (c) Approval of a nurse aide training program offered by or in a facility that participates in the Medicare or Medicaid Programs shall be denied in accordance with 42 CFR 483.151(b).
- (d) If the Department proposes to deny, suspend, or revoke approval of a nurse aide training and/or skills competency evaluation program, except where governed by the Federal requirements noted in (c) above, the facility or educational institution may, within 30 days, request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.
- (e) Suspension or withdrawal of training program approval shall not affect currently enrolled students, who shall be permitted to complete the training program unless the Department determines that continuation of the program would jeopardize the health or safety of residents in any long-term care facility.
- (f) If a nurse aide training program is discontinued for any reason, but the facility or educational institution continues to operate, the facility or educational institution shall be responsible for maintaining the records of students and graduates.
- (g) If a nurse aide training program is discontinued for any reason and the facility or educational institution ceases to operate, the records of students and graduates shall be transferred to an agency acceptable to the Department. The Department shall be advised, in writing, of the arrangements made to safeguard the records.
- (h) If a nurse aide training program is discontinued for any reason, the facility or educational institution shall:
1. Assist in the transfer of students to other approved nurse aide training programs;
  2. Provide the Department with a list of the students who have transferred to another training program, and the dates on which the students were transferred; and
  3. Notify the Department that the requirements for closing have been fulfilled and provide notice of final closing.
- (i) If a facility or educational institution plans to voluntarily discontinue a nurse aide training program, the facility or educational institution shall:

1. Provide the Department with a written statement of the rationale and plan for the intended closing;
2. Continue the program until the class established for currently enrolled students has been completed; and
3. Notify the Department, in writing, of the closing date of the program at least 90 days prior to that date.

**HISTORY:**

Amended by R.2007 d.83, effective March 19, 2007.

See: 38 N.J.R. 4141(a), 39 N.J.R. 924(a).

Added new (d); and recodified former (d) through (h) as (e) through (i).

**§ 8:39-43.14 Responsibilities of administrator**

- (a) The licensed nursing home administrator or administrator of the educational institution conducting the training program shall be responsible for implementation of the training program in accordance with the rules in this subchapter. This responsibility shall include, but not be limited to, ensuring that:
  1. The curriculum is implemented in accordance with the application as submitted and approved by the Certification Program of the Department;
  2. Resident care provided by the student does not exceed the tasks and procedures that the student has satisfactorily demonstrated, as documented by the registered professional nurse on a skills competency task form; and
  3. Job descriptions are established indicating the responsibilities of each nurse instructor/evaluator.

**§ 8:39-43.15 Employment of a nurse aide**

- (a) No licensed long-term care facility shall employ a person as a nurse aide without making inquiry to the New Jersey nurse aide registry on the Promissor website at <http://www.promissor.com>, and to any other state where the facility believes the nurse aide is registered.
- (b) The facility shall have a system in place to document compliance with (a) above.
- (c) The facility shall maintain records sufficient to verify the previous employment of nurse aides who are not currently working but whose employment at the facility makes him or her eligible for recertification in accordance with N.J.A.C. 8:39-43.6(c).

**HISTORY:**

Amended by R.2007 d.83, effective March 19, 2007.

See: 38 N.J.R. 4141(a), 39 N.J.R. 924(a).

In (a), substituted "on the Promissor website at <http://www.promissor.com>" for "at 1-800-274-8970".

**§ 8:39-43.16 Nurse aide functions**

The nurse aide shall function under the supervision and direction of a registered professional nurse and shall perform tasks that are delegated in accordance with the provisions of N.J.A.C. 13:37-6.2.

**§ 8:39-43.17 Mandatory nurse aide education and training**

- (a) A program of individualized orientation of each nurse aide shall be conducted by a registered professional nurse. The orientation program shall include resident care training and demonstrations in basic nursing skills, followed by an internship of two to five days, depending on experience.
- (b) Each nurse aide shall receive, at a minimum, 12 hours of regular in-service education per year, the content of which shall be based on the outcome of performance reviews of every nurse aide, which are completed at least once every 12 months. (The 12 hours may include topics that are covered under OBRA requirements, Pub. L. 100-239 (1989) which overlap or are duplicative of those required at N.J.A.C. 8:39-13.4(b), up to a maximum of six hours of in-service training per year.)

**§ 8:39-43.18 Fees**

- (a) In accordance with 42 CFR 483.154, as amended and supplemented, fees may be charged by the testing agency for the following:
  - 1. Clinical skills and written examination;
  - 2. Clinical skills and oral examination;
  - 3. Clinical skills and Spanish oral examination;
  - 4. Written examination only;
  - 5. Clinical skills examination only;
  - 6. Oral examination only;
  - 7. Spanish oral examination only;
  - 8. Duplicate or updated certificate, which shall be charged to the individual; and
  - 9. Recertification certificate, which shall be charged to the individual if the individual is neither currently employed nor has been offered employment by a long-term care facility.
- (b) The fee charged by the Department for a two-year approval of a training program shall be \$ 75.00.
- (c) The Department shall provide timely notice of any changes in fees specified in (a) above in the Public Notices section of the New Jersey Register.
- (d) A nurse aide who is employed by, or who has received an offer of employment from, a facility on the date on which the aide begins a nurse aide training and competency evaluation program may not be charged for any portion of the program identified in (a) above, including tuition and testing, and fees for textbooks or other required course materials.
- (e) If a nurse aide who is not employed, or does not have an offer to be employed as a nurse aide becomes employed by, or receives an offer of employment from, a licensed long-term care facility not later than 12 months after completing a nurse aide training and competency evaluation program, the facility shall provide for the reimbursement of reasonable costs incurred in completing the program. Such costs include, but are not limited to, tuition, testing, and fees for textbooks or other required course materials.
- (f) A nurse aide shall be reimbursed the costs of certification within one year of the successful completion of a reasonable probationary period established by the long-term care facility.

- (g) No nurse aide shall be required, as a condition of employment, to pay the cost of the training program in the event of voluntary or involuntary termination of employment.
- (h) All fees referenced at (a) and (b) above are non-refundable.

**HISTORY:**

Public Notice: ALA, CMA, CNA and PCA testing fees.

See: 35 New Jersey Register 2751(a).

**SUBCHAPTER 44. MANDATORY STANDARDS FOR RESPITE CARE SERVICES****§ 8:39-44.1 Scope and purpose**

- (a) Long-term care facilities are authorized by law to accept short-term residents whose regular caregivers are participating in a respite care program. A caregiver is defined as any individual, paid or unpaid, who provides regular in-home care for an elderly, disabled, or cognitively impaired person.
- (b) When a caregiver desires respite from this responsibility, continuity of care for the elderly, disabled, or cognitively impaired person is available through temporary placement in a long-term care facility for a period of time specified in advance.
- (c) The standards in this subchapter apply only to those long-term care facilities that operate a respite care program.

**§ 8:39-44.2 Mandatory policies and procedures**

- (a) The long-term care facility shall have written respite care policies and procedures that are retained by the administrative staff and available to all staff and to members of the public, including those participating in the program.
- (b) The facility shall obtain the following information from the resident's attending physician or advanced practice nurse prior to admission:
  - 1. A summary of the resident's medical history and most recent physical examination;
  - 2. Signed and dated medication and treatment orders for the resident's stay in the facility; and
  - 3. Phone numbers of the attending physician or advanced practice nurse and an alternate physician or advanced practice nurse for consultation or emergency services.
- (c) The facility shall choose whether to follow the resident care plan provided by the attending physician or advanced practice nurse or to establish a plan in accordance with N.J.A.C. 8:39-11. The facility is exempt from compliance with N.J.A.C. 8:39-11, if it chooses to follow the care plan provided by the resident's attending physician.
- (d) The facility shall obtain the following information from the resident's regular caregiver(s):
  - 1. Nursing care needs, including personal hygiene and restorative maintenance care;
  - 2. Dietary routine and preferences; and
  - 3. Social and activity routine and preferences.



- (e) The facility shall choose whether to follow the dietary, social, and resident activity plan provided by the caregiver(s) or to establish a plan in accordance with N.J.A.C. 8:39-7, 17 and 39. The facility is exempt from compliance with N.J.A.C. 8:39-7, 17 and 39, if it chooses to follow the plan provided by the caregiver(s).
- (f) The pharmacy and therapeutics committee shall establish policies and procedures for providing pharmacy services for the respite care program according to the New Jersey State Board of Pharmacy and other applicable rules and regulations. These policies and procedures shall include the following:
  - 1. Options, if any, for provision of resident medications by sources other than the facility's usual provider(s);
  - 2. Labeling and packaging of medications;
  - 3. Self-administration of medications, if applicable; and
  - 4. Control measures.
- (g) The facility shall apply to respite care residents all the standards contained in this chapter, except those exemptions cited in this section, and in the following: N.J.A.C. 8:39-4.1(a)31, 4.1(b), 5.1(a) through (e), 11.3(a), 15.1(b), 29, 35.2(d)3 through 16, and 37.3.

## **SUBCHAPTER 44A. ADVISORY STANDARDS FOR RESPITE CARE SERVICES**

### **§ 8:39-44A.1 Advisory staffing**

A long-term care facility should assign specific staff members to an individual respite care resident to provide continuity of care during the resident's stay in the facility.

## **SUBCHAPTER 45. ALZHEIMER'S/DEMENTIA PROGRAMS**

### **§ 8:39-45.1 Scope and purpose**

- (a) Long-term care facilities may establish Department approved programs to meet the needs of residents with Alzheimer's disease or other dementias. In addition to meeting all mandatory requirements specified in this chapter, the program shall provide individualized care based upon assessment of the cognitive and functional abilities of Alzheimer's and dementia residents who have been admitted to the program.
- (b) No facility shall advertise or hold itself out as providing an Alzheimer's/dementia program unless it meets the data reporting requirements of N.J.A.C. 8:39-45.2 and is recognized by the Department as meeting at least 65 percent of all current advisory standards in N.J.A.C. 8:39-46.

### **HISTORY:**

Amended by R.2005 d.157, effective May 16, 2005.

See: 36 N.J.R. 3617(a), 37 N.J.R. 1727(b).

In (b), inserted "meets the data reporting requirements of N.J.A.C. 8:39-45.2" following "Alzheimer's/dementia program unless it".

Amended by R.2006 d.72, effective February 21, 2006.

See: 37 N.J.R. 3171(a), 38 N.J.R. 1188(a).

In (b), rewrote cross reference N.J.A.C. 8:39-46.1 to include entire Subchapter 46.

**§ 8:39-45.2 Mandatory data reporting requirements**

- (a) Each facility qualified pursuant to this subchapter to hold itself out as providing an Alzheimer's/dementia program shall:
1. Compile and maintain daily records for each shift in the facility and provide to a member of the public, upon request, information that indicates for each shift, as appropriate:
    - i. The number of nurses, including the aggregate total of registered nurses and licensed practical nurses providing direct care to residents diagnosed with Alzheimer's disease and related disorders; and
    - ii. The number of certified nurse aides providing direct care to residents diagnosed with Alzheimer's disease and related disorders; and
  2. Provide a member of the public seeking placement of a person diagnosed with Alzheimer's disease and related disorders in the facility with a clear and concise written list that indicates:
    - i. The activities that are specifically directed toward residents diagnosed with Alzheimer's disease and related disorders, including, but not limited to, those designed to maintain dignity and personal identity, enhance socialization and success, and accommodate the cognitive and functional ability of a resident;
    - ii. The frequency of the activities listed in (a)2i above; and
    - iii. The safety policies and procedures and any security monitoring system that is specific to residents diagnosed with Alzheimer's disease and related disorders.
- (b) As used in this section, "Alzheimer's disease and related disorders" means the conditions defined at N.J.S.A. 26:2M-10(b).

**HISTORY:**

New Rule, R.2005 d.157, effective May 16, 2005.

See: 36 New Jersey Register 3617(a), 37 New Jersey Register 1727(b).

**SUBCHAPTER 46. ALZHEIMER'S/DEMENTIA PROGRAMS--  
ADVISORY STANDARDS****§ 8:39-46.1 Advisory Alzheimer's/dementia program policies and procedures**

- (a) The long-term care facility has written policies and procedures for the Alzheimer's/dementia program that are retained by the administrative staff and available to all staff and to members of the public, including those participating in the program.
- (b) The facility has established criteria for admission to the program and criteria for discharge from the program when the resident's needs can no longer be met, based upon an interdisciplinary assessment of the resident's cognitive and functional status.

**§ 8:39-46.2 Advisory staffing**

- (a) Staffing levels are sufficient to provide care and programming, based upon resident census in the program and an interdisciplinary assessment of the cognitive and functional status of residents in the program.

- (b) The facility has established criteria for the determination of each staff member's abilities and qualifications to provide care to residents in the program.
- (c) The facility provides an initial and ongoing educational, training and support program for each staff member which includes at least the causes and progression of dementias, the care and management of residents with dementias, and communication with dementia residents.
- (d) Each Alzheimer's/dementia program has a full-time employee, with specialized training and/or experience in the care of residents with dementia, who has been designated as coordinator/director and whose duties include responsibility for the operation of the program.
- (e) A consultant gerontologist is available to residents and to the program, as needed, to address the medical needs of the resident. "Consultant gerontologist" means a physician, psychiatrist, or geriatric advanced practice nurse who has specialized training and/or experience in the care of residents with dementia.

### **§ 8:39-46.3 Advisory environmental modification**

- (a) The program includes appropriate facility modifications to ensure a safe environment which allows each Alzheimer's/dementia resident to function with maximum independence and success.
- (b) The facility has developed safety policies and procedures and a security monitoring system which are specific to the program, based upon the physical location of the program as well as the individual needs of the Alzheimer's/dementia residents.
- (c) The facility provides indoor and outdoor arrangements that allow residents freedom to ambulate in a controlled setting.
- (d) Doors are marked with items familiar to the individual resident, which enhance the resident's ability to recognize his or her room, and bathrooms are specially marked and easily accessible.

### **§ 8:39-46.4 Advisory activity programming**

The Alzheimer's/dementia program provides a daily schedule of special activities, seven days a week and at least two evenings per week, designed to maintain residents' dignity and personal identity, enhance socialization and success, and to accommodate the various cognitive and functional abilities of each resident.

### **§ 8:39-46.5 Advisory nutrition**

- (a) The Alzheimer's/dementia program provides nutritional intervention as needed, based upon assessment of the eating behaviors and abilities of each resident. Interventions may include, but are not limited to, the following:
  - 1. Verbal and non-verbal eating cues;
  - 2. Modified cups, spoons, or other assistive devices; and
  - 3. Simplified choices of foods or utensils.
- (b) The Alzheimer's/dementia program provides a small dining room, separate room, or designated dining area furnished to meet the needs of the residents, with staff members or trained volunteers to assist.

**§ 8:39-46.6 Advisory social services**

- (a) The facility provides individual and group counseling to residents if appropriate, utilizing techniques designed to reach the dementia resident and to maintain the resident's maximum level of functioning.
- (b) Families are encouraged and provided with opportunities to participate in planning and providing resident care.
- (c) The facility provides individual and group counseling, support and education groups for families, and information and referral on bioethical and legal issues related to dementia, including competence, guardianship, conservatorship and advance directives.
- (d) Family members are referred to community Alzheimer's disease support groups or other family counseling agencies, as required.
- (e) Discharge care plans, including preparation for discharge from the unit, are discussed with the legal next of kin, and, if possible, with the resident at the time of admission to the program.

**SUBCHAPTER 47. SUBACUTE CARE UNIT IN AN ACUTE CARE GENERAL HOSPITAL****§ 8:39-47.1 Scope**

All hospital-based subacute care units shall comply with the rules in this subchapter, all other pertinent rules in this chapter, the provisions of State of New Jersey P.L. 1996, c.102, and Federal Medicare requirements at P.L. 89-97 (42 U.S.C. §§ 1395 et seq.).

**§ 8:39-47.2 Definitions**

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

"Hospital-based subacute care unit" means a distinct unit located within an acute care general hospital that utilizes licensed long-term care beds to provide subacute care.

"Subacute care" in an acute care general hospital means a comprehensive inpatient program for patients who have had an acute illness, injury, or exacerbation of a disease process, have a determined course of treatment prescribed, and do not require intensive diagnostic or intensive invasive procedures, but the patient's condition requires physician direction, intensive nursing care, frequent recurrent patient assessment and review of the clinical course and treatment plan for a period of time, significant use of ancillary medical services and an interdisciplinary approach using professional teams of physicians, nurses and other relevant professional disciplines to deliver complex clinical interventions.

**§ 8:39-47.3 Licensure of hospital-based subacute care units**

A hospital-based subacute care unit shall obtain a license to operate from the Department prior to accepting any patients. The hospital shall contact the Long-Term Care Assessment and Survey Program of the Department in order to schedule an initial licensure survey. A license shall be issued by the Long-Term Care Licensing Program only upon a finding by the Department that the unit is in compliance with the licensure requirements specified at N.J.A.C. 8:39-47.4.

**§ 8:39-47.4 Licensure requirements**

- (a) Prior to receiving a license and prior to the initial licensure survey by representatives of the Department, the hospital-based subacute care unit shall develop written clinical admission criteria and utilization review protocols as described in this section.
1. A resident of a long-term care facility who is admitted to, and discharged from, an acute care hospital shall not, upon discharge from the hospital, be admitted to the hospital-based subacute care unit, unless the long-term care facility is unable to readmit the resident within 24 hours after written notification to the long-term care facility that the resident is to be discharged from the hospital. In this case, the patient shall be discharged to the long-term care facility of origin as soon as such facility is able to readmit the individual. The hospital-based subacute care unit shall, on a daily basis, document in the patient's medical record the continuing inability of the long-term care facility of origin to readmit the patient.
  2. The hospital shall identify clinical admission criteria for its hospital-based subacute care unit which shall include:
    - i. Prospective clinical admission criteria; and
    - ii. Clinical exclusion criteria.
  3. The hospital shall specify within the clinical admission criteria that the hospital-based subacute care unit is intended for patients who will need post-acute care for eight days or fewer.
  4. Except as provided in (a)5 below, patients shall be admitted to the hospital-based subacute care unit on the recommendation of the attending physician, if such admission is in accordance with the written clinical admission and exclusion criteria.
  5. Except as set forth at (a)6 below, the hospital-based subacute care unit shall not admit a clinically stable patient with one of the diagnoses listed at (a)5i below and meeting all of the criteria for inpatient rehabilitation hospital care listed at (a)5ii below.
    - i. Nonadmissible diagnostic categories shall include patients with stroke; congenital anomaly; major multiple trauma; polyarthritis, including rheumatoid arthritis; neurological disorder, including multiple sclerosis, motor neuron disease, polyneuropathy, muscular dystrophy, and Parkinson's disease; traumatic or nontraumatic brain injury; spinal cord injury; amputation; joint replacement; fracture of the femur, including hip fracture; and burns.
    - ii. Criteria for inpatient rehabilitation hospital care shall include the following:
      - (1) The need for close medical supervision by a physician with specialized training or experience in rehabilitation;
      - (2) The need for 24-hour per day rehabilitation nursing;
      - (3) The need for a relatively intense level of rehabilitation services;
      - (4) The need for a multidisciplinary team approach to the delivery of the program;
      - (5) The need for a coordinated program of care;
      - (6) The expectation of significant practical improvement in a reasonable period of time; and
      - (7) The establishment of realistic goals of self-care or independence in activities of daily living.

6. In order to admit a patient described at (a)5 above, the hospital-based subacute care unit shall:
  - i. Forward information pertaining to the clinically stable patient to either a licensed comprehensive rehabilitation hospital or an acute care hospital which has licensed comprehensive rehabilitation beds;
  - ii. Receive a favorable recommendation from either the licensed comprehensive rehabilitation hospital or the acute care hospital which has licensed comprehensive rehabilitation beds;
  - iii. Receive a written concurring recommendation regarding the patient's admission from the case manager at the acute care hospital; and
  - iv. Receive a recommendation to admit from the patient's attending physician.
- (b) Upon determination that admission of a patient to a hospital-based subacute care unit is appropriate, information concerning the patient's rights shall be provided to the patient. Such information shall include the rights enumerated at N.J.A.C. 8:39-4 and shall assure the patient of at least the following:
  1. That, although the patient's stay is not expected to exceed eight days, the patient has the right to remain in the unit until a transfer or discharge is medically necessary to meet the patient's needs or until transfer or discharge is appropriate due to improvement in condition;
  2. That the patient shall be notified as soon as practical prior to transfer or discharge; and
  3. That, during the patient's stay, the hospital-based subacute care unit shall provide all care and services necessary to maximize the physical, mental, and psychosocial well-being of the patient.
- (c) The hospital-based subacute care unit shall establish a procedure for a patient assessment, utilizing the Standardized Resident Assessment Instrument (see N.J.A.C. 8:39-11.2(e)) to have an assessment reference date of any day, one through eight, with days one through five being optimal, but days six through eight being acceptable.
- (d) The hospital-based subacute care unit shall develop written utilization review protocols in accordance with the following:
  1. Utilization review protocols shall be prospective, concurrent, and retrospective in nature. The protocols shall be designed to verify, in all cases, the stringent use of the clinical admission criteria, the provision of continual discharge planning, and appropriateness of stay;
  2. Prospective utilization review shall occur before the patient is discharged from the acute care hospital or while the patient is completing the preadmission process for the hospital-based subacute care unit;
  3. Utilization review staff shall visit each patient and review the patient's medical record prior to admission in order to ensure that for each patient:
    - i. An appropriate length of stay is expected;
    - ii. The level of care provided in the unit is commensurate with the patient's needs; and
    - iii. A discharge plan has been prepared prior to admission;
  4. Utilization review staff shall assess each patient on the first day, the fourth day, and daily thereafter to ensure the continued appropriateness of the patient's stay in the unit; and

5. Utilization review staff shall retrospectively examine diagnostic and length of stay information concerning each admission. Such information shall be reported to the Department quarterly on a form and in a manner prescribed by the Department. The \$ 35.00 per admission health care quality fee prescribed by P.L. 1996, c.102, shall accompany submission of the form to the Department. Such form shall be submitted to the Department within 30 days after the conclusion of each quarter.

**HISTORY:**

Petition for Rulemaking.

See: 34 New Jersey Register 1975(b).

Petition for Rulemaking.

See: 35 New Jersey Register 2532(a).

Amended by R.2004 d.298, effective August 2, 2004.

See: 36 New Jersey Register 640(a), 36 New Jersey Register 3528(a).

In (d), rewrote 5.

**§ 8:39-47.5 Licensure renewal**

- (a) Renewal of a license to operate a hospital-based subacute care unit shall be based upon the unit's compliance with the rules in this subchapter, all other pertinent rules in this chapter, the provisions of State of New Jersey P.L. 1996, c.102, and Federal Medicare requirements at P.L. 89-97 (42 U.S.C. §§ 1395 et seq.).
- (b) The Department shall use the aggregate length of stay (total patient days/number of admissions) for the hospital-based subacute care unit as a monitoring benchmark, as an indicator of conformance with provisions of P.L. 1996, c.102, and as a condition of licensure renewal. For each annual renewal of the license, if the aggregate length of stay for patients admitted to the hospital-based subacute care unit during the four quarters immediately preceding the renewal application is determined to be greater than eight days, the Department shall not renew the subacute care license for the next annual licensure renewal cycle. A hospital shall not be permitted to reapply for a new certificate of need for a hospital-based subacute care unit for six months from the date of licensure nonrenewal or revocation.
  1. In the case of licensure renewal applications submitted to the Department within one year after initial licensure, the aggregate length of stay shall be determined for the three quarters immediately preceding the licensure renewal application and used by the Department in accordance with (c) above.
  2. For any patient who remains in the hospital-based subacute care unit in accordance with all provisions of N.J.A.C. 8:39-47.4(a)1, patient days accrued after the hospital has issued its written notice to discharge to the long-term care facility of origin shall not be included in the calculation of aggregate length of stay for the unit.

**HISTORY:**

Amended by R.2004 d.298, effective August 2, 2004.

See: 36 New Jersey Register 640(a), 36 New Jersey Register 3528(a).

Deleted former (b); recodified former (c) as (b).

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

- I. All Pets
  - A. Companion pets should not pose a threat or nuisance to the patients, staff, or visitors because of size, odor, sound, disposition, or behavioral characteristics. Aggressive or unprovoked threatening behavior should mandate the pet's immediate removal.
  - B. Animals which may be approved include: dogs, cats, birds (except carnivorous), fish, hamsters, gerbils, guinea pigs, and domestic rabbits. Wild animals such as turtles and other reptiles, ferrets, and carnivorous birds should not be permitted in the program.
  - C. In order to participate, dogs or cats should be either altered or determined not to be in estrus ("heat").
  - D. Sanitary constraints:
    1. Pets should be prohibited from the following areas:
      - a. Food preparation, storage, and serving areas, with the exception of participating resident's bedroom;
      - b. Areas used for the cleaning or storage of human food utensils and dishes;
      - c. Vehicles used for the transportation of prepared food;
      - d. Nursing stations, drug preparation areas, sterile and clean supply rooms;
      - e. Linen storage areas; and
      - f. Areas where soiled or contaminated materials are stored.
    2. Food handlers should not be involved in the cleanup of animal waste.
    3. The administrator is responsible for acceptable pet husbandry practices and may delegate specific duties to any other staff members except food handlers. The areas of responsibility include: feeding and watering, food cleanup/cage cleaning, exercising, and grooming.
    4. Spilling or scattering of food and water should not lessen the standard of housekeeping or contribute to an increase in vermin or objectionable odor.
    5. Dogs and cats must be effectively housebroken and provisions made for suitably disposing of their body wastes.
    6. Animal waste should be disposed of in a manner which prevents the material from becoming a community health or nuisance problem and in accordance with applicable sanitation rules and ordinances. Accepted methods include disposal in sealed plastic bags (utilizing municipally approved trash removal systems) or via the sewage system for feces.
    7. Proper and frequent handwashing shall be a consideration of all persons handling animals.
  - E. Animals found to be infested with external parasites (ticks, fleas, or lice) or which show signs of illness (for example, vomiting or diarrhea) should be immediately removed from the premises and taken to the facility's veterinarian.
  - F. The parent or guardian of a child bitten by a dog, cat, or other animal, when no physician attends such child, shall, within 12 hours after first having knowledge



- that the child was so bitten, report to the person designated by law or by the local board, under authority of law, to receive reports of reportable communicable diseases in the municipality in which the child so bitten may be the name, age, sex, color, and precise location of the child (N.J.S.A. 26:4-80). If an adult is bitten by a dog, cat, or other animal and no physician attends him, the adult, or, if he is incapacitated, the person caring for him, shall report to the person designated by law or by the local board of health to receive reports of communicable diseases in the municipality in which the adult so bitten may be the name, age, sex, color, and the precise location of the adult. The report shall be made within 12 hours after the adult was so bitten, or if he is incapacitated, the report shall be made within 12 hours after the person caring for him shall first have knowledge that the adult was so bitten (N.J.S.A. 26:4-81).
- G. The local health department must be promptly notified by telephone of any pet that dies on the premises.
1. If the deceased is a bird, the body should be immediately taken to the facility's veterinarian. If the veterinarian is not available, the deceased bird should be securely wrapped in impermeable wrapping material and frozen until veterinary consultation is available. Payment for a laboratory examination should be the responsibility of the institution, or the pet's owner.
  2. If the deceased is another type of animal, the body should not be disposed until it is determined by the local department of health that rabies testing is not necessary.
- H. The rights of residents who do not wish to participate in the pet program must be considered first. Patients not wishing to be exposed to animals should have available a pet free area within the participating facility.
- II. Visiting Pets
- A. Visiting pets are defined as any animal brought into the facility on a periodic basis for pet therapy purposes. The owner should accompany the animal and be responsible for its behavior and activities while it is visiting at the facility.
- B. Visiting dogs should:
1. Be restricted to the areas designated by the facility administrator;
  2. Maintain current vaccination against canine diseases of distemper, hepatitis, leptospirosis, parainfluenza, parvovirus, coronavirus, bordetella (kennel cough), and rabies. Proof of vaccination shall be included on a health certificate that is signed by a licensed veterinarian and kept on file at the facility;
  3. Be determined not to be in estrus ("heat") at the time of the visit;
  4. Be licensed and wear an identification tag on the collar, choker chain, or harness, stating the dog's name, the owner's name, address, and telephone number; and
  5. Be housebroken if more than four months of age. Younger dogs may be admitted subject to the approval of the administrator.
- C. Visiting cats should:
1. Maintain current vaccination against feline pneumonitis, panleukopenia, rhinotracheitis, calicivirus, chlamydia, and rabies. Proof of vaccination should be included on a health certificate that is signed by a licensed veterinarian and kept on file at the facility; and

2. Determined not be in estrus ("heat") at the time of the visit.
  - D. Visiting hamsters, gerbils, guinea pigs, domestic rabbits, laboratory mice, or rats:
    - 1 The owner should be liable and responsible for the animal's activities and behavior.
  - E. No visiting birds should be allowed to participate in the program.
- III Residential Pets
- A. Residential pets are defined as any animal that resides at a facility in excess of four hours during any calendar day and is owned by a staff member, patient, the facility, or a facility approved party. The financial responsibility for the residential animal's maintenance is the animal owner's responsibility.
  - B. All documentation of compliance will be maintained by the facility administrator in a file for review and inspection. The official health records should include the rabies vaccination certificate and a current health certificate.
  - C. Residential animals should have a confinement area separate from the patients where they can be restricted when indicated. An area should be available for each participating unit and should be approved by the administrator.
  - D. A licensed veterinarian should be designated as the facility's veterinarian and should be responsible for establishing and maintaining a disease control program for residential pets.
  - E. Specific Species:
    1. Residential dogs should:
      - a. Maintain current vaccination against canine diseases of distemper, hepatitis, leptospirosis, parainfluenza, parvovirus and rabies. In addition, the animal's file should include a currently valid Rabies Vaccination Certificate, NASPHV #51. A three-year type rabies vaccine should be utilized;
      - b. Have an annual heartworm test commencing at one year of age and should be maintained on heartworm preventive medication;
      - c. Have a fecal examination for internal parasites twice yearly. Test results should be negative before the dog's initial visit to the facility;
      - d. Follow the recommended procedures of the facility's veterinarian for controlling external parasites;
      - e. Be neutered;
      - f. Be licensed with the municipality and wear an identification tag on the collar, choker chain, or harness, stating the dog's name, the owner's name, address, and telephone number;
      - g. Have a health certificate completed by a licensed veterinarian within one week before the animal's initial visit to the facility. The certificate should be updated annually thereafter;
      - h. Be immediately removed from the premises and taken to the facility's veterinarian if infested with internal or external parasites, vomit, or have diarrhea, or show signs of a behavioral change or infectious disease. Medical records of the veterinarian's diagnosis and treatment should be maintained in the animal's file. The animal should not have patient contact until authorized by the facility's veterinarian;
      - i. Be housebroken if more than four months of age. Younger dogs may be admitted subject to the requirements of the administrator;

- j. Be fed in accordance with the interval and quantity recommended by the facility's veterinarian. Feeding and watering bowls should be washed daily and stored separately from dishes and utensils used for human consumption;
  - k. Be provided fresh water daily and have 24-hour access to the water dish;
  - l. Be provided a suitable bedding area. Bedding should be cleaned or changed as needed. Dirty bedding should be processed or disposed of as necessary;
  - m. Be permitted outside the facility only if under the supervision of a staff member, a responsible person or within a fenced area; and
  - n. Be regularly groomed and receive a bath whenever indicated.
2. Residential birds:
- a. Should be treated by a licensed veterinarian with an approved chlortetracycline treatment regimen prior to being housed at the institution to ensure the absence of psittacosis. The period of treatment varies between 30 to 45 days and is species-dependent. A signed statement from the veterinarian indicating such treatment should be kept in the bird's file; and
  - b. That die, or are suspected of having psittacosis, should be immediately taken to the facility's veterinarian. In the event the bird dies and the veterinarian is not available, the bird's body should be securely wrapped in impermeable wrapping material and frozen until veterinary consultation is available.
3. Residential hamsters, gerbils, guinea pigs, domestic rabbits, laboratory mice or rats should be examined yearly by a licensed veterinarian for health status. A health certificate should be completed for each animal or group of animals. Any animal that becomes sick or dies should be promptly taken to the facility's veterinarian.

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

- I. The initial resident assessment should include a psychosocial behavior component with interventions, if appropriate, in the care plan. Reassessment should be done at least quarterly, or at any time when a resident's pattern of behavior changes. Resident response to interventions should be recorded in the medical record.
- II. Inappropriate behavior and/or actions should trigger an immediate reassessment with adjusted interventions; notification of the physician and/or the designated resident representative. Resident response should be recorded in the medical record. The facility's actions/interventions in response to behavior changes should also be part of the plan of care and should be appropriately recorded. Prompt reassessment of behavioral changes will in most cases avert the continued progression of inappropriate behavior.
- III. Inappropriate behavior and/or actions involving other residents should be identified in the records of all involved residents including assessments, interventions and responses. Notifications of physician and/or designated resident representatives should also be recorded in medical records of all involved residents.
- IV. Incidents of inappropriate behavior or actions of abuse between residents should result in the following actions, as applicable:
  - A. Immediate assessments of involved residents;
  - B. Notification of attending physicians or advanced practice nurses;
  - C. Interventions and responses of residents;
  - D. Notification of residents' designated representatives;
  - E. Protection of involved residents' civil and constitutional rights;
  - F. Determination by administrator of facility's ability to assure safety and security of all patients;
  - G. Implementation of emergency or short-term precautions to assure safety while working toward resolution; and
  - H. Notification of police if necessary.
- V. In the event that it is determined that a resident must be removed from the facility, the transfer should be initiated in accordance with the provisions of this chapter.
- VI. Transfer from the facility should be based on the appropriate evaluation and transfer order of the attending physician, advanced practice nurse, facility medical director and/or consultant psychiatrist.
- VII. In the event of an immediate emergency situation only:
  1. Have patient removed to emergency room of local hospital for medical and/or psychiatric evaluation and consultation by a physician or advanced practice nurse. Return of patient to the long-term care facility should be based on the physician's or advanced practice nurse's written notation of the appropriateness of returning the resident to the long-term care setting. The administrator is responsible for the decision to accept or deny the return of the resident according to N.J.A.C. 8:39;

2. A police complaint should be filed against the abuser and have the individual removed. The complaint can be filed by the facility or the abused party; and
  3. Notify all agencies (that is, Medicaid if applicable, Ombudsman for the Institutionalized Elderly, if applicable (over 60) and the Department of Health and Senior Services.)
- VIII. In the event all guidelines have been followed and resolution has not taken place, assistance should be requested from the Department.
- IX. Facility policies and procedures to address inappropriate resident behavior, including resident to resident abuse, should include all of the above outlined actions.
- X. To determine resident's emotional adjustment to the nursing facility, including his/her general attitude, adaptation to surroundings, and change in relationship patterns, the following areas should be evaluated:
1. **Sense of Initiative/Involvement Intent:** To assess degree to which the resident is involved in the life of the nursing home and takes initiative in activities. **Process:** Selected responses should be confirmed by the resident's behavior (either verbal or nonverbal) over the past seven days. The primary source of information is the resident. Secondarily, staff members who have regular contact with the resident should be consulted (for example, nursing assistants, activities personnel, social work staff, or therapists if the person receives active rehabilitation). Also, consider how resident's cultural standards affect the level of initiative or involvement. **Definition:** At ease interacting with others--Consider how resident behaves during time you are together, as well as reports of how resident behaves with other residents, staff, and visitors. Does resident try to shield himself/herself from being with others? Does he/she spend most time alone? How does he/she behave when visited? At ease doing planned or structured activities--Consider how resident responds to such activities. Does he/she feel comfortable with the structure or restricted by it? At ease with self-initiated activities--These include leisure activities (for example, reading, watching TV, talking with friends), and work activities (for example, folding personal laundry, organizing belongings). Does resident spend most of his/her time alone, or does resident always look for someone to find something for him/her to do? Establishes his/her own goals--Consider statements resident makes like, "I hope I am able to walk again," or "I would like to get up early and visit the beauty parlor." Goals can be as traditional as wanting to learn how to walk again following a hip replacement, or wanting to live to say goodbye to a loved one. Some things may not be stated **Involvement in life of the facility--**Consider whether resident partakes of facility events, socializes with peers, discusses activities. Resident accepts invitations into most group activities--Is resident willing to try group activities even if later, deciding the activity is not suitable and leaving? Does resident regularly refuse to attend group programs?
  2. **Unsettled Relationships Intent:** To indicate the quality and nature of the resident's interpersonal contacts (that is, how resident interacts with staff members, family, and other residents). **Process:** During routine nursing care activities, observe how the resident interacts with staff members and with other residents. Do you see signs of conflict? Talk with direct-care staff (for example, nursing assistants, dietary aides who assist in the dining room, social work staff, or activities aides) and ask for their observations of behavior that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that the staff members describing these relationships may be biased. **Definition:** Covert/open conflict with and/or repeated criticism of staff--Resident chronically complains about some staff members to other staff members; resident verbally criticizes

- staff members in therapeutic group situations, causing disruption within the group; or resident constantly disagrees with routines of daily living. (Note: Checking this item does not require any assumption about why the problem exists or how it could be remedied.) Unhappiness with roommate--Includes frequent requests for roommate changes, grumbling about roommate spending too long in the bathroom, or complaints about roommate rummaging in another's belongings. Unhappiness with residents other than roommate--Includes chronic complaints about the behaviors of others, poor quality of interaction with other residents, lack of peers for socialization. This refers to conflict or disagreement outside of the range of normal criticisms or requests (that is, beyond a reasonable level). Openly expresses conflict/anger with family or close friends--Includes expressions of feelings of abandonment, ungratefulness, lack of understanding, or hostility regarding relationships with family/friends. Absence of personal contact with family/friends--Absence of visitors or telephone calls from significant others in the last seven days. Recent loss of close family member/friend--Includes relocation of family member/friend to a more distant location, even temporarily (for example, for the winter months); incapacitation or death of a significant other; a significant relationship that recently ceased.
3. Past Roles Intent: To indicate recognition or acceptance of feelings regarding role or status now that the person is in the nursing home. Definition: Strong identification with past roles and life status--This may be indicated, for example, when resident enjoys telling stories about own past; or takes pride in past accomplishments or family life; or prefers to be connected with prior lifestyle (for example, celebrating family events, carrying on life-long traditions). Expresses sadness/anger/empty feelings over lost roles/status--Resident expresses feelings such as "I'm not the man I used to be" or "I wish I had been a better mother to my children" or "It's no use; I'm not capable of doing the things I always liked to do." Resident cries when reminiscing about past accomplishments. Be careful not to take the reaction out of context. Process: Discuss past life with resident. Use environmental cues to prompt discussions (for example, family photos, grandchildren's letters or artwork). This information may emerge from discussions around other MDS topics (for example, Customary Routine, Activity Pursuits, ADLs). Direct-care staff may also have useful insights relevant to these items.
- XI. To determine resident's mood and behavior patterns, the following elements should be considered:
- 1 Sad or Anxious Mood Intent: To identify the presence of behaviors that may be interpreted as physical or verbal expressions of sadness or anxiety. Definition: A distressed mood characterized by explicit verbal or gestural expressions of feeling depressed or anxious (or a synonym such as feeling sad, miserable, blue, hopeless, empty, or tearful). This may be a disorder of mood which is usually, but not always, accompanied by a painful mood of such magnitude that it calls for relief because it is severely, or unnecessarily, distressing or threatening to physical health and life, or interferes with functional performance and adaptation. These symptoms may be preceded by anger or withdrawal. Process: Determine if resident expressed signs of a sad or anxious mood over the past 30 days. Draw on your own interactions with the resident. Pay particular attention to statements of direct-care staff, social workers, and licensed personnel who may have evaluated the resident in this area. Does the resident cry or look dejected (unhappy) when no one is talking with him/her? When you talk with the resident, does he/she sound hopeless, fearful, sad, anxious? Does the resident report feelings of worthlessness, guilt? Does the resident appear withdrawn, apathetic, without emotion? If you are unsure, seek confirming information from others who

- regularly come in contact with the resident (for example, activities professionals, social workers, or family members).
2. **Mood Persistence Intent:** To identify a persistent sad/anxious mood that has existed on each day over the last seven days and was not easily altered by attempts to "cheer up" the resident. Process: Normally, these moods apply to one or more of the indicators mentioned above of sad/anxious mood.
  3. **Problem Behavior Intent:** To identify the presence of problem behaviors in the last seven days that cause disruption to facility residents or staff members, including those that are potentially harmful to the resident or disruptive in the environment, even though staff and residents appear to have adjusted to them (for example, "Mrs. R's calling out isn't much different than others on the unit; there are many noisy residents.") Definition: Wandering--Movement with no identified rational purpose; resident appears oblivious to needs or safety. This behavior must be differentiated from purposeful movement--for example, a hungry person moving about the unit in search of food; pacing. Report on the most disruptive resident behavior across all three shifts. Code "1" if the described behavior occurred less than daily and "2" if the behavior occurred daily or more frequently.
  4. **Resident Resists Care Intent:** Identify problem behaviors related to delivering care/ treatment to the resident. These behaviors are not necessarily positive or negative; they provide observational data. They may prompt further investigation of causes in the care-planning process (for example, fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness to participate in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided). Process: Consult medical record and primary staff caregiver. How does the resident respond to staff members' attempts to deliver care to him/her? Signs of resistance may be verbal and/or physical (for example, verbally refusing care, pushing caregiver away, scratching).
  5. **Behavior Management Program Intent:** Determine if a behavior-management program is in place wherein staff members identified causal factors and developed a plan of action based on that understanding. There must be evidence of structure and continuity of care in the program (for example, written documentation). This category does NOT include behavioral management by physical restraints or psychoactive drugs, if these are the only interventions used. Process: Consult medical record (including current care plan); consult primary caregiver. Examples Mrs. S has been observed on numerous occasions to hit, shove, and curse the woman seated next to her at each meal. After observing the pattern of Mrs. S's behavior for several days, staff noticed that her tablemate was in the habit of moving toward Mrs. S to take food from her tray. As a result of their observations, the primary nurse made a change in seating arrangements. (Note: Although staff might have increased the amount of food provided at meals, the real issue was the taking of food; Mrs. S would not want to share with others, no matter how much food she was given.) Mrs. S does not tend to ask staff for help when she is annoyed; she takes direct and aggressive action on her own. Now that staff understand this behavior, they are aware of the need to be vigilant. Code "1" for Yes. Provisions were made for safety monitored wandering for Mr. V (including use of "secure bands" that activate an alarm if he wanders away from a designated area). Mr. V does not really disturb others (he does not go into others' rooms). Without this "band," however, staff lost track of him and he was in danger of harming himself if he got off the unit (a busy street is very near his unit). Code "1" for Yes.

6. Change in Mood Intent: Determine whether the resident's mood changed in the past 90 days, that is, onset of recent mood problem or changes in a longstanding problem. Changes may have been expressed verbally or demonstrated physically; they include increased/decreased number of signs/symptoms, or increase/decrease in the frequency, intensity, or persistence of sad or anxious mood. Examples Mrs. D has a long history of depression. Two months ago she had an adverse reaction to a psychoactive drug. She expressed fears that she was going out of her mind and was observed to be quite agitated. Her attention span diminished and she stopped attending group activities because she was disruptive. After the medication was discontinued, these feelings and behaviors improved. She is better than she was, but still has feelings of sadness. Code "1" for "Improved." Mrs. D is now better than her worst status in the 90-day period, but she has not fully recovered. (Note: If the mood problem was no longer present due to the continued efficacy of the treatment program, the correct code would also be "1" (Improved).) Mrs. Y has bipolar disease. Historically, she has responded well to lithium and her mood state has been stable for almost a year. About two months ago, she became extremely sad and withdrawn, expressed the wish that she were dead, and stopped eating. She was transferred to a psychiatric hospital. For the last 30 days (following readmission), Mrs. Y has improved and her appetite is restored. Code "1" for Improved.
7. Change in Problem Behavior Intent: Determine if problem behaviors or resistance to care increased/decreased in number, frequency, or intensity in the past 90 days--that is, onset of recent behavior problems or changes in a more longstanding problem. Changes can occur in many different areas, including (but not limited to) wandering, verbal or physical abuse, socially inappropriate behavior, or resistance to care. Changes can be exhibited as increases/decreases in the number of signs/symptoms and/or change in the frequency or intensity of the behavior(s). Process: Review nursing notes, medical records, and consult with primary staff caregiver.



**APPENDIX C****GUIDELINES FOR THE USE OF RESTRAINTS**

- A Written policies and procedures for use of restraints should address at least the following:
1. Protocol for the use of alternatives to restraints, such as staff or environmental interventions, structured activities, or behavior management. Alternatives should be utilized whenever possible to avoid the use of restraints;
  2. Protocol for the use and documentation of a progressive range of restraining procedures from the least restrictive to the most restrictive;
  3. A delineation of indications for use, which should be limited to:
    - i. Prevention of imminent harm to the resident or other persons when other means of control are not effective or appropriate; or
    - ii. Prevention of serious disruption of treatment or significant damage to the physical environment;
  4. Contraindications for use, which should include, at least, clinical contraindications, convenience of staff, or discipline of the resident;
  5. Identification of restraints which may be used in the facility, which should be limited to methods and mechanical devices that are specifically manufactured for the purpose of physical restraint. Locked restraints, double restraints on the same body part, four-point restraints, and confinement in a locked or barricaded room should not be permitted;
  6. Protocol for informing the resident and obtaining consent when clinically feasible, and documenting the consent in the resident's record;
  7. Protocol for notifying the family or guardian, obtaining consent if the resident is unable to give consent, and documenting the consent in the resident's record; and
  8. Protocol for removal of restraints when goals have been accomplished.
- B. Procedures for the application of restraints in an emergency should include at least the following:
1. Licensed nursing staff only should initiate the use of emergency restraints;
  2. The application of restraints should begin with the least restrictive alternative that is clinically feasible;
  3. Emergency restraints should be used only when the safety of the resident or others is endangered, or there is imminent risk that the resident will cause substantial damage to the physical environment;
  4. The facility should notify the attending physician or advanced practice nurse or another designated physician and request an order within two hours;
  5. The facility should obtain a physician's or advanced practice nurse's order within eight hours;
  6. Licensed nursing personnel should evaluate and document the physical and mental condition of the resident in emergency restraints at least every two hours;
  7. There should be an assessment of the resident by a registered professional nurse within 24 hours; and

8. Continuation of emergency restraints should occur only upon physician or advanced practice nurse orders, which should be renewed every 24 hours to a maximum of seven days.
- C. The facility should continuously attempt to remediate the resident's condition to eliminate or lessen the need for restraints. If the use of restraints is needed beyond one week, at least the following should be done:
1. The need for the continued use of restraints should be implemented only as part of the physician's medical care plan;
  2. Every resident in restraints should be assessed by a registered professional nurse at least every 48 hours for the continued use of restraints; and
  3. After remediation attempts, there should be an interdisciplinary review of the record of any resident whose assessment indicates the need for continued use of restraints. This review should occur within thirty days of the initiation of the use of restraints.
- D. Continuation of the use of restraints beyond 30 days should occur only upon written approval of the committee or its equivalent, and should include at least the following actions:
1. The registered professional nurse should assess the need for continued restraints at least weekly; and
  2. An interdisciplinary review should be conducted at least every 30 days to approve the continued use of restraints.
- E. The facility should have written policies and procedures to ensure that interventions while a resident is restrained, except as indicated in F below, are performed by nursing personnel in accordance with nursing scope of practice as set forth by the New Jersey Board of Nursing. The policies and procedures should include at least the following:
1. Periodic visual observation, which should be performed with the following frequency:
    - i. Continuously, if clinically indicated by the resident's condition; or
    - ii. At least every 15 minutes while the resident's condition is unstable; and thereafter at least every one to two hours, based upon an assessment of the resident's condition.
  2. Release of restraints at least once every two hours in order to:
    - i. Assess circulation;
    - ii. Perform skin care;
    - iii. Provide an opportunity for exercise or perform range of motion procedures for a minimum of five minutes per restrained limb and repositioning; and
    - iv. Assess the need for toileting and assist with toileting or incontinence care.
  3. Ensuring adequate fluid intake;
  4. Ensuring adequate nutrition through meals at regular intervals, snacks, and assistance with feeding if needed;
  5. Assistance with bathing as required at least daily; and
  6. Ambulation at least once every two hours, if clinically feasible.
- F. The facility should have written policies and procedures for interventions by nursing personnel for residents in restraints for overnight sleeping. These policies and

procedures should include at least the following and should be implemented in accordance with nursing scope of practice, as set forth by the New Jersey Board of Nursing;

1. Visual observation based on resident's condition, occurring at least every one to two hours;
2. Administration of fluids as required;
3. Toileting as required;
4. Release of restraints at least once every two hours for repositioning and skin care, if clinically indicated; and
5. Prohibition of any method of restraint which places the resident at clinical risk for circulatory obstruction.

**APPENDIX D****APPLICATION FOR A HEALTH CARE FACILITY  
LICENSE****APPENDIX E****APPLICATION FOR A HEALTH CARE FACILITY  
LICENSE RENEWAL****APPENDIX F****RESIDENT CARE STAFFING REPORT, FORM  
HFEL-6**