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HEALTH

HEALTH SYSTEMS BRANCH

DIVISION OF CERTIFICATE OF NEED AND LICENSING

Rehabilitation Hospital Licensing Standards

Proposed New Rules: N.J.A.C. 8:43H

Authorized By: Kaitlan Baston, MD, MSc, DFASAM, Commissioner (with the approval of the Health Care Administration Board).

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

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2024-080.

Submit written comments by August 30, 2024, electronically to www.nj.gov/health/legal/ecomments.shtml or by mail to:

Kimberly Jenkins, J.D., Director

Office of Legal and Regulatory Compliance

Office of the Commissioner

New Jersey Department of Health

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The agency proposal follows:

Summary

The Department of Health (Department) proposes new rules at N.J.A.C. 8:43H to establish the comprehensive rehabilitation hospital licensing standards. This chapter

first became effective in August 1989. 21 N.J.R. 1067(a); 2476(b). N.J.A.C. 8:43H was readopted without change on June 17, 1994. 26 N.J.R. 1628(a); 2896(c). Pursuant to Executive Order No. 66 (1978), N.J.A.C. 8:43H expired June 1999. N.J.A.C. 8:43H was adopted as new rules effective November 15, 1999. N.J.A.C. 8:43H was readopted effective April 22, 2005. 36 N.J.R. 1843(a); 37 N.J.R. 1728(a). N.J.A.C. 8:43H expired on April 22, 2010. 36 N.J.R. 4908(a); 37 N.J.R. 1728(a). Establishing these minimum requirements would continue a high level of quality care for patients in rehabilitation hospitals.

The proposed new rules include 17 subchapters. Proposed new Subchapter 1, General Provisions and Qualifications, would establish the scope and purpose of the chapter. New N.J.A.C. 8:43H-1.1 would set forth the purpose of the chapter. New N.J.A.C. 8:43H-1.2 would set forth the scope of the chapter. Proposed new N.J.A.C. 8:43H-1.3 would define words and phrases that the chapter uses. Proposed new N.J.A.C. 8:43H-1.4(a) would incorporate by reference N.J.A.C. 8:43G, Hospital Licensing Standards, subchapters that apply to rehabilitation hospitals. Proposed new N.J.A.C. 8:43H-1.4(b) would provide that rehabilitation hospitals shall be subject to the requirements at N.J.A.C. 8:43E, General Licensure Procedures and Standards Applicable to All Licensed Facilities.

Proposed new Subchapter 2 would establish the rehabilitation hospital licensure process. Proposed new N.J.A.C. 8:43H-2.1 would establish requirements for the certificate of need process to initiate or expand comprehensive rehabilitation services. In addition, proposed new N.J.A.C. 8:43H-2.1 would establish the Department's enforcement of conditional certificate of need approval and ability to impose sanctions,

should a facility fail to comply with these conditions. Proposed new N.J.A.C. 8:43H-2.2 and 2.3 establish the voluntary functional review process to assist potential new comprehensive rehabilitation providers to seek guidance and consultation from the Department concerning the proper implementation of the licensure requirements and/or a preliminary determination of whether a proposed facility or service complies with the applicable licensure rules.

Proposed new N.J.A.C. 8:43H-2.4 would establish the application fee schedule, including the application filing and inspection fees; fees for licensure renewal; applications to add or reduce beds; the relocation of a rehabilitation hospital, and transfer of ownership fees. Proposed new N.J.A.C. 8:43H-2.5 would establish the process for initial licensure application, application review, initial survey, and license issuance. Proposed new N.J.A.C. 8:43H-2.6 would establish a process for the renewal of a license. Proposed new N.J.A.C. 8:43H-2.7 would establish a process for when a rehabilitation hospital must surrender a license and a process for cessation of operations. Proposed new N.J.A.C. 8:43H-2.8 would establish requirements for the transfer of ownership of a rehabilitation hospital. N.J.A.C. 8:43H-2.9 would establish requirements for newly constructed or expanded rehabilitation hospitals.

Proposed new N.J.A.C. 8:43H-2.10 would establish that rehabilitation hospitals are subject to survey by the Department at any time and would establish a process for surveys. Proposed new N.J.A.C. 8:43H-2.11 would establish requirements for applying for and standards for the granting of a waiver from the requirements of this chapter. Proposed new N.J.A.C. 8:43H-2.12 would establish enforcement actions that may be taken against a rehabilitation hospital. Proposed new N.J.A.C. 8:43H-2.13 would

establish penalties to be imposed upon entities that advertise as providing comprehensive hospital rehabilitation services without being licensed as a rehabilitation hospital. Proposed new N.J.A.C. 8:43H-2.14 would require licensees to update their license information whenever any information included in a license or renewal application changes. Proposed new N.J.A.C. 8:43H-2.15 would allow a rehabilitation hospital to offer primary care services through free-standing off-site ambulatory care service facilities and hospital-based off-site ambulatory care service facilities.

Proposed new Subchapter 3 would establish the services to be provided by a rehabilitation hospital, personnel requirements, and the policy and procedure manual. Proposed new N.J.A.C. 8:43H-3.1 would establish services to be provided by rehabilitation hospitals and requirements for how these services are to be provided. Proposed new N.J.A.C. 8:43H-3.2 would establish disclosure of a rehabilitation hospital's ownership and that changes in ownership be reported to the Department. Proposed new N.J.A.C. 8:43H-3.3 would establish personnel policy requirements, including the need for written job descriptions; licensure, certification, or authorization for patient care personnel, as required pursuant to the laws and rules of the State of New Jersey; written staffing schedules; development and implementation of staff orientation and education plans; and at least one person trained in cardiopulmonary resuscitation in all patient areas when patients are present.

Proposed new N.J.A.C. 8:43H-3.4 would require written policy and procedure manuals for the operation of a facility to be developed, implemented, and reviewed at regular intervals and made available at all times to Department representatives, patients, staff, and the public. Proposed new N.J.A.C. 8:43H-3.5 would require written

agreements for services that are provided by contract or subcontract. N.J.A.C. 8:43H-3.5 also specifies the minimum contents of these written agreements and would establish a rehabilitation hospital's responsibilities for the services provided pursuant to these contracts. Proposed new N.J.A.C. 8:43H-3.6 would set forth a rehabilitation hospital's responsibility for reportable events.

Proposed new N.J.A.C. 8:43H-3.7 would require a rehabilitation hospital to conspicuously post a notice that information is available in the facility during normal business hours regarding waivers granted by the Department; all documents required by this chapter; a list of the rehabilitation hospital's committees and their membership; and policies and procedures regarding patient rights. A facility would be required to maintain for public review in the administrator's office information regarding the membership of the governing authority and changes to the membership within 30 days after the change.

Proposed new N.J.A.C. 8:43H-3.8 would establish a rehabilitation hospital's reporting responsibility to the Medical Practitioner Review Panel and the Clearing House Coordinator required pursuant to the Health Care Professional Responsibility and Reporting Enhancement Act, P.L. 2005, c. 83, and the Department's rules at N.J.A.C. 8:30. Proposed new N.J.A.C. 8:43H-3.9 would establish the preparation of financial reports.

Proposed new Subchapter 4 would set forth the rehabilitation hospital's governing authority. Proposed new N.J.A.C. 8:43H-4.1 would require rehabilitation hospitals to have a governing authority that is responsible for the operation,

management, and financial viability of a facility, and would set forth the responsibilities of the governing authority.

Proposed new Subchapter 5 relates to the administration of rehabilitation hospitals. Proposed new N.J.A.C. 8:43H-5.1 would require a rehabilitation hospital's governing authority to appoint a chief executive/administrator, who is available to the facility at all times and is accountable for the rehabilitation services. Proposed new N.J.A.C. 8:43H-5.2 would institute the administrator's responsibilities.

Proposed new N.J.A.C. 8:43H-5.3 would require rehabilitation hospitals to establish policies and processes for advanced directives; dispute resolution, including patient, responsible person, and staff discussion forums and community education programs. Proposed new N.J.A.C. 8:43H-5.4 would establish policies and procedures for advance directives and declaration of death that are consistent with the New Jersey Advanced Directives for Health Care Act (N.J.S.A. 26:2H-53 et seq.); the New Jersey Declaration of Death Act (N.J.S.A. 26:6A-1 et seq.); and the patient's religious beliefs concerning the declaration of death.

Proposed new N.J.A.C. 8:43H-5.5 would establish policies and procedures for the implementation of the Practitioner Orders for Life-Sustaining Treatment Act (POLST), N.J.S.A. 26:2H-129 et seq. Proposed new N.J.A.C. 8:43H-5.6 would establish policies and procedures for the admission of a pediatric patient who is at least 16 years of age and under 20 years of age, provided that, for patients ages 16 or 17, the hospital notifies the patient's parent or legal guardian on admission to an adult rehabilitation hospital. Proposed new N.J.A.C. 8:43H-5.7 would establish a process for the admission of an adult patient 20 years or older to a pediatric rehabilitation hospital.

Proposed new Subchapter 6 would address patient care standards. Proposed new N.J.A.C. 8:43H-6.1 would require the establishment, implementation, and review of written patient care policies and procedures. This would include policies and procedures concerning the admission, orientation, transfer, readmission, referral, and discharge of patients, and care of deceased patients. The policies and procedures would also need to address patient rights, sexual counseling, environmental modification services, staffing levels based on patient acuity, emergency care, informed consent, financial arrangements, telephone orders, smoking, interpretation and communication services, the care and control of assistive animals and pets, and the care of deceased patients. This section also would require that, in the event of an accident or incident that does not result in injury to the patient, notification of the responsible person is to occur within 24 hours of the occurrence, except in the case of a competent adult (N.J.A.C. 8:43H-6.1). In addition, the subchapter would require written protocols for the rehabilitation hospital's use of restraints, including identifying the types of restraints to be used at a facility, and the use of alternatives to restraints, such as staff or environmental interventions, structured activities, or behavioral management. This subchapter also would require that physical restraints shall be used when authorized, in writing, by a physician, except if necessitated by an emergency.

Proposed new Subchapter 7 would establish standards for developing preadmission assessment and interdisciplinary care plans using the patient's assessment. Proposed new N.J.A.C. 8:43H-7.1 would require a patient to have a preadmission assessment before admission to a rehabilitation hospital. Proposed new N.J.A.C. 8:43H-7.2 would require an interdisciplinary care plan to be developed for each

patient, under the direction of a rehabilitation physician, based on the treatment team's assessment of the individual. The interdisciplinary plan would be initiated upon admission, would be completed within four days of admission, and would measure the patient's improvements on a once-a-week basis to assess the readiness for discharge. Proposed new N.J.A.C. 8:43H-7.3 would establish the contents of the interdisciplinary plan and would establish conditions for participation by the patient and responsible person: in the development of the interdisciplinary plan. Proposed new N.J.A.C. 8:43H-7.3 would also outline the implementation of the interdisciplinary plan and the participation of its members.

Proposed new Subchapter 8 would establish licensure standards for medical services. Proposed new N.J.A.C. 8:43H-8.1 would require medical services to be available to all patients 24 hours a day, seven days a week. Proposed new N.J.A.C. 8:43H-8.2 would require a rehabilitation hospital to appoint a medical director who shall provide medical services in accordance with facility bylaws and policies in a rehabilitation hospital. Proposed new N.J.A.C. 8:43H-8.3 would establish the responsibilities of the medical director in a rehabilitation hospital. Proposed new N.J.A.C. 8:43H-8.4 would establish the responsibilities of medical physicians in a rehabilitation hospital. Proposed new N.J.A.C. 8:43H-8.4, specifically, would require the medical physician primarily providing care to a patient directly to participate as part of the interdisciplinary care team in developing the patient's care plan. Proposed new N.J.A.C. 8:43H-8.5 would require a pediatrician to be available if a facility provides care to pediatric patients and new N.J.A.C. 8:43H-8.6 would require that if a medical director of a rehabilitation hospital providing services to pediatric patients is a pediatrician, a

rehabilitation physician shall be available, in accordance with medical bylaws and facility policies and procedures.

Proposed new Subchapter 9 would establish standards for the provision of nursing services. Proposed new N.J.A.C. 8:43H-9.1 would require a rehabilitation hospital to make nursing services available 24 hours a day, seven days a week, directly within the rehabilitation hospital. Proposed new N.J.A.C. 8:43H-9.1 would also establish minimum nurse staffing requirements and responsibilities for the development and supervision of the staff orientation and education provided to nursing personnel. Under the direction of the nursing service, rehabilitation hospitals shall adopt or create a curriculum for the development and implementation of a training program for unlicensed assistive personnel. Proposed new N.J.A.C. 8:43H-9.2 would require the written appointment of a nursing leader to be responsible for the rehabilitation nursing service and to be available at all times, with a registered nurse designated, in writing, to act in the absence of the nursing leader. Proposed new N.J.A.C. 8:43H-9.3 would establish the responsibilities of the nursing leader responsible for rehabilitation nursing services. Proposed new N.J.A.C. 8:43H-9.4 would establish the responsibilities of the licensed nursing personnel. Proposed new N.J.A.C. 8:43H-9.5 would establish the role of nursing services as related to pharmaceutical services.

Proposed new Subchapter 10 would establish standards for the provision of pharmaceutical services. Proposed new N.J.A.C. 8:43H-10.1 would require pharmacy services to be available 24 hours a day, seven days a week, directly within the facility. The rehabilitation hospital may use an automated medication system. Usage of an automated medication system shall comply with N.J.A.C. 10:39-10. If a facility has an

institutional pharmacy, the pharmacy would be required to be licensed by the New Jersey State Board of Pharmacy (NJSBP), operate in accordance with NJSBP rules, and possess a current Drug Enforcement Administration registration and a Controlled Dangerous Substance registration from the Department.

Proposed new N.J.A.C. 8:43H-10.2 would require the appointment of a pharmacist and would establish the pharmacist's responsibilities. Proposed new N.J.A.C. 8:43H-10.3 would require a facility's governing authority to appoint a multidisciplinary pharmacy and therapeutics committee and would establish its responsibilities for developing policies and procedures for the storage and administration of drugs. Proposed new N.J.A.C. 8:43H-10.4 would establish the content of a rehabilitation hospital's policies and procedures for drug administration. Proposed new N.J.A.C. 8:43H-10.5 would require a pharmacist to periodically inspect all areas of a facility where drugs are dispensed, administered, or stored and to maintain records of those inspections. Proposed new N.J.A.C. 8:43H-10.6 includes requirements for drugs to be stored and controlled in accordance with the New Jersey Pharmacy Practice Act, N.J.S.A. 45:14-40 et seq., and the New Jersey Board of Pharmacy Rules, N.J.A.C. 13:39.

Proposed new Subchapter 11 would require the provisions of occupational therapy, physical therapy, speech-language therapy, and orthotics/prosthetics directly within a rehabilitation hospital. Proposed new N.J.A.C. 8:43H-11.1 would require that a facility provide each adult patient at least three hours of services per day, five days per week. Services would include any one or combination of the following as determined by the interdisciplinary team, in collaboration with the patient and/or the responsible person

occupational therapy, physical therapy, speech-language therapy, and orthotics/prosthetics five days per week. Proposed new N.J.A.C. 8:43H-11.1(d) would require that a facility provide each pediatric patient with rehabilitation therapy services, as determined by the interdisciplinary team in collaboration with the patient and/or responsible person. Pediatric rehabilitation therapy services may include occupational therapy, physical therapy, speech-language therapy, and orthotics/prosthetics five days per week. The provisions of a pediatric patient's therapy shall include physical or occupational therapy. Proposed new N.J.A.C. 8:43H-11.2 would require a facility to appoint an occupational therapist, physical therapist, speech-language pathologist, and orthotist/prosthetist to be responsible for the direction, provision, and quality of their respective services and would establish responsibilities for each of these individuals.

Proposed new N.J.A.C. 8:43H-11.3 identifies the statutory authority and responsibilities for speech-language pathologists, occupational therapists, physical therapists, speech-language pathologists, and orthotist/prosthetists, as well as their involvement in an interdisciplinary team and interdisciplinary care plan with the other appropriate health care professionals. Proposed new N.J.A.C. 8:43H-11.4 addresses the provision of consultant services not available in the rehabilitation hospital and provided on an outpatient basis. Spaces for therapists are addressed at N.J.A.C. 8:43H-11.5 for occupational therapy services, physical therapy services, speech-language pathology, and orthotics/prosthetics.

Proposed new Subchapter 12 would establish minimum standards for social work and psychological services. Proposed new N.J.A.C. 8:43H-12.1 would require rehabilitation hospitals to provide counseling services in the form of social work services

or psychological services directly at a facility. Proposed new N.J.A.C. 8:43H-12.2 would require a facility to appoint a social worker or a psychologist to be responsible for the direction, provision, and quality of their respective services and would establish responsibilities for each of these individuals. Proposed new N.J.A.C. 8:43H-12.3 would require each social worker or psychology staff member, in accordance with written job descriptions and within their scope of practice, to provide patient care and be a participant in the interdisciplinary team and to be involved in assessing, developing, implementing, and reassessing the interdisciplinary care plan, when indicated. Spaces for therapists are addressed at proposed N.J.A.C. 8:43H-12.4 for psychology services and social work services.

Proposed new Subchapter 13 would establish minimum requirements for emergency procedures. Proposed new N.J.A.C. 8:43H-13.1 would require an emergency plan for a facility that includes plans and procedures to be followed in case of medical emergencies, equipment breakdown, fire, or other disasters. Emergency procedures would be required to include individuals to be notified, emergency equipment locations and alarm signals, evacuation routes, procedures for evacuating patients, frequency of fire drills, and tasks and responsibilities assigned to all staff. The section also would require that the emergency plan and emergency procedures be conspicuously posted at wheelchair height throughout a facility. Proposed new N.J.A.C. 8:43H-13.2 would require simulated emergency drills to be conducted and documented on each shift at least four times each year; random testing of the emergency plan that includes at least one manual pull alarm three times per quarter to promote patient

safety; and annual examination and maintenance of fire extinguishers in accordance with manufacturer and National Fire Protection Association requirements.

Proposed new Subchapter 14 would establish requirements for discharge planning. Proposed new N.J.A.C. 8:43H-14.1 would require each patient to have a discharge plan, that discharge planning is initiated at an early stage of the patient's hospitalization, is part of a facility plan, involves responsible persons, if applicable, and includes instructions given to the patient or responsible person for care following discharge. Proposed new N.J.A.C. 8:43H-14.2 would require the establishment and implementation of written policies and procedures for discharge services and prescribes the content of these policies and procedures.

Proposed new Subchapter 15 would establish minimum requirements for a quality improvement program. Proposed new N.J.A.C. 8:43H-15.1 would require rehabilitation hospitals to establish and implement a quality assurance program for patient care that would specify a timetable and the persons responsible for the program and address staff monitoring, clinical competencies, and patient care services. Proposed new N.J.A.C. 8:43H-15.2 specifies the quality improvement activities to be undertaken by a rehabilitation hospital. Proposed new N.J.A.C. 8:43H-15.3 would require staff responsible for the quality assurance program to submit the results of the quality assurance program to the governing authority and would require a facility's governing authority to take measures to improve quality based on the results of the quality assurance program.

Proposed new Subchapter 16 would establish physical plant standards for rehabilitation hospitals. Proposed new N.J.A.C. 8:43H-16.1 would establish standards

for the construction, alteration, or renovation of rehabilitation facilities, and would require compliance with the New Jersey Uniform Construction Code (Use Group I-2), standards imposed by the United States Department of Human Services, the Americans with Disabilities Act, and with the Guidelines for Design and Construction of Hospitals published by the Facility Guidelines Institute and referred to as the "FGI Guidelines."

Proposed new Subchapter 17 would establish functional service area requirements for rehabilitation facilities. Proposed new N.J.A.C. 8:43H-17.1 would require that the facilities be accessible to the physically disabled pursuant to the Americans with Disabilities Act. Proposed new N.J.A.C. 8:43H-17.2 would establish the types of functional service areas that must be maintained by a rehabilitation hospital. Proposed new N.J.A.C. 8:43H-17.3 would establish functional service area requirements for medical evaluation services.

The following proposed new sections would establish functional service areas for the type of service that follows the section in parenthesis: N.J.A.C. 8:43H-17.4 (patient dining, recreation therapy, and community spaces); 17.5 (dietary services and nutritional counseling); 17.6 (administration services); 17.7 (patient rooms and nursing units); 17.8 (radiology services); 17.9 (laboratory services); 17.10 (sterilization of medical equipment); 17.11 (linen services); 17.12 (housekeeping services); 17.13 (employees facilities); 17.14 (engineering service and equipment areas); 17.16 (pediatric educational services); 17.16 (facility details); and 17.17 (facility finishes).

As the Department is providing a 60-day comment period for this notice of proposal, this notice is excepted from the rulemaking calendar requirement, pursuant to N.J.A.C. 1:30-3.3(a)5.

Social Impact

The proposed new rules would ensure that high-quality, effective care is provided to patients in licensed rehabilitation hospitals and would protect patient health and safety.

Individuals affected by the proposed new rules would include patients who, due to disease or injury that impairs functioning, require comprehensive rehabilitation services and specialized integrated care to reach an attainable degree of independence. The Department expects that the proposed new rules would have a favorable social impact on both patients and the 15 licensed rehabilitation hospitals. Patient care would be provided through an interdisciplinary approach, with an interdisciplinary care plan that is initiated upon the patient's admission and tailored to the patient's clinical responses by the interdisciplinary team. A rehabilitation hospital would provide an intensive rehabilitation therapy program that consists of at least three hours of therapy per day, five days per week. In certain cases, intensive rehabilitation therapy programs may consist of at least 15 hours of intensive rehabilitation therapy within a seven consecutive calendar-day period beginning on the date of admission.

Overall, the proposed new rules would maintain the quality of services for patient care and the quality of the staff's performance in the delivery of those services.

The proposed new rules would require facilities to participate in quality improvement activities to evaluate each patient's needs, expectations, and satisfaction, and to develop a patient care outcome system that is based on industry-accepted indicators. Facility-wide functions, such as staffing, infection control, housekeeping, and

maintenance would reflect current practitioner requirements, public health practices, and building codes.

Economic Impact

The Department expects that the proposed new rules would have a positive impact on the rehabilitation hospital community and patients in need of their services. The proposed new rules would assist acute care facilities in discharging patients to comprehensive rehabilitation hospitals more expeditiously and would prevent the unnecessary and costly transfer of patients to intermediary environments.

The proposed new rules would allow facilities flexibility in management practices, such as developing policies and procedures best suited to their circumstances and determining staffing qualifications to meet patient care needs and rehabilitation goals. The proposed new rules would provide the latitude needed for facilities to conserve resources by allowing them to determine the most efficient manner to utilize services and personnel. The use of an interdisciplinary team approach would foster cost-efficient use of a facility's resources so that an interdisciplinary plan can be developed with specific rehabilitation goals and timeframes.

Discharge planning is another requirement of the proposed new rules that would help to control costs. Effective discharge planning would be initiated within 24 hours of the patient's admission, with the participation of the interdisciplinary team, the patient, and the responsible person. Effective discharge planning would help to prevent improper post-discharge placements and facilitate the patient's transition to a setting commensurate with the level of care needed, and in which a discharged individual can attain full potential. Well-planned post-discharge care is effective in avoiding potential

costs associated with inappropriate placements, service gaps, or interruption of services.

The proposed new rules would not impose any additional economic burden on the regulated community beyond what is already required by the expired chapter. The proposed new rules maintain the standards for the treatment environment in the previously expired rules, and thereby improve patients' abilities to function at maximum capacity and avoid long-term institutionalization.

Federal Standards Analysis

The proposed new rules are similar to the Medicare standards, established pursuant to 42 CFR Parts 412 and 482, with which rehabilitation hospitals must comply to be Medicare-certified. The proposed new rules would exceed the Federal Medicare certification standards in the following areas: employee health requirements, especially for direct patient care; policies and procedures regarding patient rights; and the establishment of an infection prevention and control program. The proposed new rules would be consistent with licensure rules for comparable New Jersey health care facilities. The Department believes it appropriate to exceed the Federal standards because the health and welfare of rehabilitation hospital patients are no less important than the health and welfare of patients in other State-licensed health care facilities or services.

The costs of compliance are not significant, in that they require health screening tests, such as TB tests, and implementation of patient rights requirements within the context of the general provision of services. The proposed infection prevention and control program requirements are necessary, due to the increase in treatment-resistant

diseases because rehabilitation hospital patients are susceptible to communicable diseases. The cost of prevention is minimal and is far less than the cost of treatment.

Jobs Impact

The Department does not expect that any jobs would be generated or lost in the State of New Jersey as a result of the proposed new rules.

Agriculture Industry Impact

The proposed new rules would have no impact on the agriculture industry of the State of New Jersey.

Regulatory Flexibility Statement

The proposed new rules would impose requirements only on comprehensive rehabilitation hospitals licensed in New Jersey, which are not “small businesses,” within the meaning of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., as each comprehensive rehabilitation hospital employs more than 100 people full-time. Therefore, the proposed new rules impose no requirements on small businesses, and no regulatory flexibility analysis is necessary.

Housing Affordability Impact Analysis

The proposed new rules would have no impact on the affordability of housing in New Jersey, nor would they evoke a change in the average costs associated with housing because the proposed new rules would establish standards for the licensing of rehabilitation hospitals and would have no bearing on housing development or costs.

Smart Growth Development Impact Analysis

The proposed new rules would not have any impact on the achievement of smart growth, nor would they evoke a change in housing production in Planning Areas 1 or 2,

or within designated centers, pursuant to the State Development and Redevelopment Plan in New Jersey because the proposed new rules would establish standards for the licensing of rehabilitation hospitals and would have no bearing on housing development or costs.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

The Department has evaluated this rulemaking and determined that it would not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the proposed new rules follows:

CHAPTER 43H

REHABILITATION HOSPITAL LICENSING STANDARDS

SUBCHAPTER 1. GENERAL PROVISIONS AND QUALIFICATIONS

8:43H-1.1 Purpose

Rehabilitation hospitals are designed to provide comprehensive inpatient rehabilitation services to patients due to complications of their nursing, medical management, and rehabilitation needs. The purpose of this chapter is to establish minimum rules to which a rehabilitation hospital is to adhere to obtain a license to operate in New Jersey and to maintain that license in good standing.

8:43H-1.2 Scope

This chapter applies to facilities that provide comprehensive rehabilitation services, including hospitals that provide these services as separate services. These

rules constitute the basis for the licensure of rehabilitation hospitals by the New Jersey Department of Health.

8:43H-1.3 Definitions

(a) The following words and terms, when used in this chapter, shall have the meanings that the New Jersey Pharmacy Practice Act, N.J.S.A. 45:14-40 et seq., particularly at 45:14-41, and/or the rules of the State Board of Pharmacy, N.J.A.C. 13:39, particularly at N.J.A.C. 13:39-1.2, establish for those terms unless the context clearly indicates otherwise:

"Biological product";

"Compounding";

"Drug or medication";

"Pharmacist"; and

"Therapeutically equivalent."

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

"Activity of daily living" or "ADL" means a function or task for self-care that a person performs either independently or with supervision or assistance. 1. Activities of daily living include at least: bathing, bed mobility, dressing and undressing, eating, locomotion, transferring, and toilet use.

"Adult patient" means a patient who is 20 years of age or older.

"Advance directive" means an "advance directive for health care" or "advance directive" as the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq., defines that term.

"American Board of Pediatrics" or "ABP" means the entity by that name for which the contact information is: mailing address 111 Silver Cedar Court, Chapel Hill, NC 27514, website https://www.abp.org, and telephone (919) 929-0461. ABP includes any future names of this organization

"American Osteopathic Board of Pediatrics" or "AOBP" means the entity by that name for which the contact information is: mailing address 142 E. Ontario Street, Chicago, IL 60611-2864, website https://certification.osteopathic.org/pediatrics, and telephone (888) 626-9262 or (312) 202-8267. AOBP includes any future names of this organization.

"Association of Rehabilitation Nurses" or "ARN" means the entity by that name for which the contact information is: mailing address 8735 West Higgins Road, Suite 306, Chicago, IL 60631-2738, website https://rehabnurse.org, and telephone (800) 229-7530. ARN includes any future names of this organization.

"Bylaws" means a set of rules that a rehabilitation hospital adopts that govern its operation. A charter, articles of incorporation, and/or a statement of policies and objectives are acceptable equivalents.

"Cleaning" means the removal by scrubbing and washing, using hot water, soap or detergent, and/or vacuuming, to remove infectious agents and organic matter from surfaces on which infectious agents may find conditions for surviving or multiplying.

“Clinical note” means a written, signed, and dated notation that a health care professional makes upon rendering a service to a patient.

“Commissioner” means the Commissioner of the New Jersey Department of Health.

“Comprehensive rehabilitation services” means the coordinated and integrated delivery of rehabilitation therapy by an interdisciplinary care team to a patient who requires, and can participate in and benefit from, these services, to maximize the patient’s independence.

“Conspicuously post” means place at wheelchair height at a location within the rehabilitation hospital that is accessible to and seen by patients and the public.

“Department” means the New Jersey Department of Health.

"Dietitian" means a person who is registered or eligible for registration by the Commission on Dietetic Registration (Office on Dietetic Credentialing).

“Discharge plan” means a written plan initiated at an early stage of a patient’s hospitalization, which includes at least an evaluation of the patient’s needs, the development of goals for discharge, and referrals to community agencies and resources for services following discharge.

“Division of Consumer Affairs” means the Division of Consumer Affairs established in the Department of Law and Public Safety, pursuant to N.J.S.A. 52:17B-120.

“Division of Health Facility Survey and Field Operations” or “DHFSFO” means the Division within the Department that surveys and inspects licensed health care facilities,

for which the contact information is PO Box 367, 120 South Stockton St., Lower Level, Trenton, NJ, 08625-0367, https://www.nj.gov/health.

"Documented" means written, signed, and dated.

"Drug administration" as used in this chapter, means a procedure in which a prescribed drug or biological product is given to a patient by an authorized person in accordance with all laws and regulations governing such procedures.

1. The complete procedure for administration consists of:

i. Removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container);

ii . Verifying that the dose matches the prescriber's orders;

iii. Verifying the patient's identity;

iv. Giving the individual dose to the patient;

v. Seeing that the patient takes it; and

vi. Recording the required information, including the method of administration.

"Facility Guidelines Institute" or "FGI Guidelines" means the 2022 edition of the Guidelines for Design and Construction of Hospitals, which are incorporated into this chapter, as amended and supplemented, published by the American Guidelines Institute, email info@fgiguidelines.org; website www.fgiguidelines.org.

"Floor stock" means medications from a pharmacist in a labeled container in limited quantities that are not necessarily prescribed for one or more specific individuals.

“Governing authority” means the organization, person, or persons designated by the licensee to assume legal responsibility for the management, operation, and financial viability of the rehabilitation hospital.

"Health care representative" means a person who is authorized to make health care decisions on behalf of a patient.

"Hospital-based off-site ambulatory care service facility" means an ambulatory care service facility that has met the criteria license provisions set forth at N.J.A.C. 8:43A.

“Interdisciplinary care plan” means a written, individualized plan of care for each patient that a rehabilitation physician develops with input from the interdisciplinary care team members who are participating in the patient’s care based upon their assessment of the patient and plans for rehabilitation intervention.

“Interdisciplinary care team” means, at a minimum, a rehabilitation physician, an individual representative from nursing, a social worker or case manager, and a licensed or certified therapist from each therapy discipline treating the patient, who work together to plan, provide, and evaluate a comprehensive, integrated program of care to the patient.

“Intravenous infusion admixture service” means the preparation, by pharmacy personnel, of intravenous infusion solutions requiring compounding and/or reconstitution.

“Job description” means written specifications developed for each position in the rehabilitation hospital, containing the qualifications, duties, responsibilities, and accountability required of employees in that position.

“Licensed nursing personnel” or “licensed nurse” means a registered professional nurse or licensed practical nurse.

“Licensed practical nurse” or “LPN” means a person to whom the New Jersey Board of Nursing in the Division of Consumer Affairs of the Department of Law and Public Safety issues licensure as a licensed practical nurse, pursuant to N.J.S.A. 45:11-23 et seq., and N.J.A.C. 13:37.

"Medical director" means a licensed Doctor of Medicine or Osteopathy who is designated by the hospice as having overall responsibility for the medical component of the rehabilitation hospital.

“Monitor” means to observe, watch, or check.

“Nursing leader accountable for nursing services” means a registered professional nurse who:

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

2. Has a bachelor’s degree; and

3. Within two years of appointment:

i. Has been issued by the Association of Rehabilitation Nurses, a certification as a Certified Rehabilitation Registered Nurse (CRRN), in accordance with the certification standards at http://www.rehabnurse.org/certification/content/Index.html; or

ii. Has a certification comparable to certification as a CRRN.

“Nursing unit” means a continuous area on one floor, which includes patients’ rooms.

“Occupational therapist” means a person to whom the Occupational Therapy Advisory Council in the Division of Consumer Affairs of the Department of Law and Public Safety issues licensure as an occupational therapist, pursuant to N.J.S.A. 45:9-37.51 et seq., and N.J.A.C. 13:44K.

"Orthotic" means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hoses, canes, crutches, cervical collars, dental appliances, or other similar devices.

"Orthotist" means any person who practices orthotics and who is representing himself or herself to the public by title or by description of services, incorporating such terms as "orthotics," "orthotists," "orthotic," or "L.O." or any similar title or description of services, provided that the individual has met the eligibility requirements set forth at N.J.S.A. 45:12B-11 and N.J.A.C. 13:44H-3.1, and has been licensed pursuant to N.J.S.A. 45:12B-1 et seq.

“Pediatric patient” means a patient who is under 20 years of age.

“Pediatrician” means a physician who is certified as a pediatrician by either:

1. The American Board of Pediatrics; or

2. The American Osteopathic Board of Pediatrics.

"Pharmaceutical services" means all patient-oriented services provided by pharmacists or other pharmacy personnel specific to their scope of practice. These services shall be concerned with, but not limited to, interpreting the prescription or medication order; selecting, preparing, compounding, packaging, labeling, distributing, and dispensing prescribed drugs; the proper and safe storage of drugs; the monitoring of drug therapy; the reporting and recording of adverse drug reactions and the provision

of appropriate drug information; and teaching and counseling on the proper and safe use of drugs and medications.

"Physical therapist" means a person to whom the New Jersey State Board of Physical Therapy in the Division of Consumer Affairs of the Department of Law and Public Safety issues licensure as a physical therapist, pursuant to N.J.S.A. 45:9-37.12 et seq., and N.J.A.C. 13:39A.

"Physician" means a person to whom the New Jersey State Board of Medical Examiners in the Division of Consumer Affairs of the Department of Law and Public Safety issues licensure to practice medicine, pursuant to N.J.S.A. 45:9-1 et seq., and N.J.A.C. 13:35.

"Practitioner Orders for Life-Sustaining Treatment form" or "POLST form" means the term "Practitioner Orders for Life-Sustaining Treatment form" or "POLST form" as the Practitioner Orders for Life-Sustaining Treatment Act, N.J.S.A. 26:2H-129 et seq., defines that term, particularly at 26:2H-131. See https://nj.gov/health/advancedirective/polst.

"Preadmission screening" means an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by a licensed or certified clinician(s) within 48 hours immediately prior to the rehabilitation hospital admission.

"Prescriber" means a person who is authorized to write prescriptions in accordance with Federal and State law.

“Progress note” means a written, signed, and dated notation summarizing information about health care that is provided to a patient, and the patient’s response to the care.

"Prosthetic" means any artificial device that is not surgically implanted and that is used to replace a missing limb, appendage, or any other external human body part, including devices such as artificial limbs, hands, fingers, feet, and toes, but excluding dental appliances and largely cosmetic devices that could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

"Prosthetist" means a person who practices prosthetics and who represents himself or herself to the public by title or by description of services, under a title incorporating such terms as "prosthetics," "prosthetist," "prosthetic," or "L.P." or any similar title or description of services and has been licensed pursuant to N.J.S.A. 45:12B-1 et seq.

“Psychologist” means a person to whom the New Jersey State Board of Psychological Examiners in the Division of Consumer Affairs of the Department of Law and Public Safety issues licensure as a psychologist, pursuant to N.J.S.A. 45:14B-40 et seq., and N.J.A.C. 13:42.

"Reconstruction" means any project where the extent and nature of the work is such that the work area cannot be occupied while the work is in progress and where a new certificate of occupancy is required before the work area can be reoccupied. Reconstruction may include repair, renovation, alteration, or any combination thereof. Reconstruction shall not include projects comprised only of floor finish replacement, painting or wallpapering, or the replacement of equipment or furnishings. Asbestos

hazard abatement and lead hazard abatement projects shall not be classified as reconstruction solely because occupancy of the work area is not permitted.

“Registered professional nurse” means a person who is licensed by the New Jersey Board of Nursing in the Division of Consumer Affairs of the Department of Law and Public Safety, pursuant to N.J.S.A. 45:11-23 et seq,. and N.J.A.C. 13:37.

“Rehabilitation hospital” means a facility, or a distinct unit located in a facility, that provides preventive, diagnostic, therapeutic, and rehabilitative services to patients either directly or under contractual arrangements and is licensed and operates pursuant to this chapter.

"Renovation" means the removal and replacement or covering of existing interior or exterior finish, trim, doors, windows, or other materials with new materials that serve the same purpose and do not change the configuration of space.

"Responsible person" means a person who has been designated as a patient's healthcare representative, attorney-in-fact, guardian, or other legal representative for purposes of making healthcare decisions on behalf of the patient.

“Restraint” means a physical device or chemical (drug) used to limit, restrict, or control patient movements and is not associated with therapeutic interventions or protocols.

“Self-administration” means a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a patient to themselves.

“Shift” means a time period defined as a full working day by the rehabilitation hospital in its policy manual.

“Signature” shall include 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 and may include a controlled electronic signature.

“Social worker” means a person providing direct social work services and who is licensed by the Board of Consumer Affairs of the New Jersey Department of Law and Public Safety, pursuant to N.J.A.C. 13:44G.

"Speech-language pathologist" means a person who is so licensed by the Director of the Division of Consumer Affairs of the New Jersey Department of Law and Public Safety in accordance with N.J.S.A. 45:3B-1 et seq., and N.J.A.C. 13:44C.

“Staff education plan” means a written plan developed at least annually and implemented throughout the year which describes a coordinated program for each service, including in-service programs and on-the-job training.

“Sterilization” means a process of destroying all microorganisms, including those bearing spores, in, on, and around an object.

“Unlicensed assistive personnel” or “UAP” means unlicensed individuals (formerly known as “ancillary nursing personnel”) to whom selective nursing tasks are delegated in accordance with N.J.A.C. 13:37-6.2.

8:43H-1.4 General hospital requirements

(a) A rehabilitation hospital shall comply with, and is subject to, the following standards at N.J.A.C. 8:43G, Hospital Licensing Standards:

1. N.J.A.C. 8:43G-4, Patient Rights;

2. N.J.A.C. 8:43G-10, Dietary;

3. N.J.A.C. 8:43G-13, Housekeeping, Laundry, and Sanitation;

4. N.J.A.C. 8:43G-14, Infection Control;

5. N.J.A.C. 8:43G-15, Medical Records; and

6. N.J.A.C. 8:43G-20, Employee Health.

(b) A rehabilitation hospital shall be subject to the requirements at N.J.A.C. 8:43E, General Licensure Procedures and Standards Applicable to All Licensed Facilities.

SUBCHAPTER 2. HOSPITAL LICENSURE

8:43H-2.1 Certificate of need

(a) Pursuant to N.J.S.A. 26:2H-1 et seq., a rehabilitation hospital shall not be instituted, constructed, expanded, or licensed to operate, except upon application for, and the Commissioner's issuance of a certificate of need, pursuant to N.J.A.C. 8:33.

(b) Application forms for a certificate of need, CN-3, are available at N.J.A.C. 8:33 and on the Department's website at www.nj.gov/health/forms.

(c) A rehabilitation hospital shall submit the application and fee required pursuant to N.J.A.C. 8:33-4.3 and implement all conditions imposed by the Commissioner, as specified in the certificate of need approval letters.

8:43H-2.2 Functional review applicability

(a) An applicant for rehabilitation hospital licensure may voluntarily seek guidance and consultation from the Department concerning the proper implementation of licensure requirements and/or a preliminary determination of whether a proposed rehabilitation

hospital or service complies with applicable physical plant licensure standards, including, but not limited to, the provisions in this chapter.

(b) Requests for a functional review shall be, in writing, specifying the type of facility and/or service proposed, and shall be forwarded to the Director, Certificate of Need and Healthcare Facility Licensure Program.

(c) Requests for a functional review shall be submitted by mail to:

Director, Office of Certificate of Need and Healthcare Facility Licensure
Division of Certificate of Need and Licensing
New Jersey Department of Health
PO Box 358
Trenton, NJ 08625-0358

(c) There shall be no fee charged for functional review.

(d) Functional review is conducted prior to submission of plans to the Department of Community Affairs. Therefore, a functional review does not include the survey required pursuant to N.J.A.C. 8:43H-2.5 and the review of the Certificate of Occupancy, Certificate of Continuing Occupancy, or a Certificate of Approval required pursuant to N.J.A.C. 8:43H-2.10 for a newly constructed or expanded facility.

(e) Requests for functional review shall include the following, as applicable:

1. A written project narrative, prepared with the assistance of a licensed architect or engineer, which includes:

i. A description of the project, including location and time frame for implementation;

ii. Projected staffing levels and staff qualifications;

iii. A physical plant description and floor plans with dimensions;

iv. A written description of the project scope and timeframe for completion; and

v. A statement that the applicant understands and will comply with all operational licensing and physical plant requirements.

2. A schematic floor plan of the facility that is prepared to a recognized drawing scale of one-eighth (1/8) or one-quarter (1/4) of an inch per foot with door swings, plumbing fixtures shown and labeled with the intended use of each room.

i. The schematic floor plan shall show all fixtures, including, but not limited to, door swings, patient beds, sinks, toilets, showers, built-in counters, and refrigerators.

ii. A licensed architect or engineer shall prepare the schematic floor plan, with the architect or engineer's completed title block affixed to the schematic floor plan; and

3. A site plan or key plan showing the location of the proposed building on the property, the areas designated for drop-off of patients and delivery of supplies, and the availability and location of disabled access and parking.

(f) Following receipt of a completed request, the Department shall conduct a functional review within 60 days of the request.

1. If a functional review request is incomplete, the Department shall provide notice to the applicant of any deficiencies in the application.

2. Following the review of a complete functional review request, the Department shall provide to the applicant a written determination either approving or denying the

functionality of the proposed project, together with the reasons therefor, and any limitations or conditions of future licensure approval, where applicable.

3. The Department may extend the functional review period, if necessary.

i. If a requester so requests, the determination shall contain the Department's assessment of the availability of a waiver of otherwise applicable physical plant requirements.

8:43H-2.3 Functional review approval

(a) Requests for a functional review shall be, in writing, specifying the type of facility and/or service proposed, and shall be forwarded to the Director, Certificate of Need and Healthcare Facility Licensure Program.

(b) Notwithstanding any provision of this chapter, functional review approval is advisory only and shall not serve as a guarantee of eventual licensure approval in any case.

(c) Notwithstanding any provision of this chapter, to obtain licensure, and thereafter, every rehabilitation hospital and/or service shall comply with applicable licensure standards in effect.

8:43H-2.4 Application fees

(a) The Department shall charge nonrefundable fees in accordance with the following schedule for applications for initial licensure and applications from existing rehabilitation hospitals:

1. Initial licensure and annual renewal $10,000;

2. Biennial inspection fee $5,000;

3. Add beds or services $3,000;

4. Reduce beds or services $375.00;

5. Relocate a rehabilitation hospital $1,500; and

6. Transfer ownership of a rehabilitation hospital $1,500.

(b) The Department shall deny any of the application types described in this chapter, if a rehabilitation hospital fails to pay applicable fees.

8:43H-2.5 Application for licensure

(a) Any person, organization, or corporation desiring a license to operate a rehabilitation hospital in the State shall apply to the Commissioner by submitting a completed Application for New or Amended Acute Care Facility License, CN-7, which is available on the Department's website at www.nj.gov/health/forms.

1. An incomplete application will not be accepted and will be returned to the applicant.

2. The applicant will then be notified and requested to submit the "entire" application/documents/fees.

(b) An applicant for initial licensure shall request the DHFSFO to conduct a survey of the rehabilitation hospital once it is ready for occupancy.

(c) Representatives of the DHFSFO shall notify the applicant of the scheduled date of the survey and shall survey the rehabilitation hospital on that date to determine if the rehabilitation hospital complies with this chapter and other applicable standards.

(d) Following the survey, representatives of the DHFSFO shall discuss the findings of the survey, including any deficiencies found, with representatives of the applicant and

shall transmit a written report of deficiency findings and shall specify the date by which the applicant is to correct any deficiencies identified therein.

(e) The applicant shall submit a written report of its correction of deficiencies identified in the written report of deficiency findings to the DHFSFO by the date specified in the written report of deficiency findings.

(f) Following the review of an applicant's report of deficiency correction, the DHFSFO may resurvey the rehabilitation hospital one or more times before authorizing occupancy.

(g) Subject to the payment of applicable fees pursuant to N.J.A.C. 8:43H-2.4, the Department may issue a rehabilitation hospital license valid for one year upon an applicant's satisfaction of the following conditions:

1. The applicant has submitted to the Certificate of Need and Healthcare Facility Licensure Program, Division of Certificate of Need and Licensing, Department of Health, PO Box 358, Trenton, New Jersey 08625-0358, telephone 609-292-6552, email CNandLicensingRequests@doh.nj.gov; application forms available at https://www.nj.gov/health/healthfacilities/certificate-need/#1:

i. A completed CN-7 application for New or Amended Acute Care Facility License;

ii. Copies of applicable written approvals of the local zoning, fire, health, and building authorities;

iii. Copies of the certificate of occupancy or continued occupancy of the local municipality;

iv. Projected staffing levels and staff qualifications;

v. A physical plant description and floor plans with dimensions;

vi. A statement that the applicant understands and will comply with all operational licensing and physical plant requirements;

vii. Any requests for waivers to operational licensing and physical plant requirements as permitted, including all arguments that would support approval of the request at N.J.A.C. 8:43H-2.11;

viii. A list of the names, locations, types, and Medicare provider numbers, as applicable, of all licensed healthcare facilities operated or managed by the applicant or any principals, in New Jersey and, in the case of new licensees, in all other states; and

ix. Other information the applicant determines to be necessary and appropriate for the Department's consideration;

2. The rehabilitation hospital complies with applicable licensure standards;

3. The applicant has the ability to provide quality of care commensurate with applicable licensure standards, and an acceptable record of past and current compliance with applicable Federal and in-State and out-of-State licensure requirements for new licensees, in accordance with N.J.A.C. 8:33-4.10(d).

i. For the review required pursuant to this paragraph, a rehabilitation hospital shall be considered in the general or special hospital licensing category as defined at N.J.A.C. 8:33-4.10(d)8ii; and

4. All staff have documented competencies in rehabilitation in accordance with rehabilitation hospital policies.

(h) With respect to a rehabilitation hospital unit within a licensed hospital, in addition to meeting the requirements at (g) above, the unit shall satisfy the following conditions:

1. The unit has the capacity to serve a minimum census of 30 beds;

2. The unit has a registered professional nurse assigned solely to the unit at all times; and

3. During every 24 hours, at least 50 percent of all other licensed and unlicensed nursing personnel are individuals assigned solely to the rehabilitation service and who do not float from non-rehabilitation units or agencies.

(i) Concerning a free-standing rehabilitation hospital, in addition to meeting the requirements at (g) above, the rehabilitation hospital shall have the capacity to serve a minimum census of 60 beds.

(j) A licensee shall post the license in a conspicuous location at the rehabilitation hospital.

(k) A licensee shall not accept patients until the Department issues written authorization and/or a license issued by the Department.

8:43H-2.6 Renewal of a license

(a) The Department shall assess a biennial inspection fee every other year upon application for licensure renewal, in addition to the annual licensure fee for that year.

(b) Approximately 30 days prior to the expiration of the license of a rehabilitation hospital, the Department shall transmit a form of application for renewal of licensure to the rehabilitation hospital and, if applicable in that year, an invoice assessing the biennial inspection fee.

(c) At least 30 days prior to the annual expiration of a license, the Department shall issue to the licensee a request for submission of the renewal fee established pursuant to N.J.A.C. 8:43H-2.4.

(d) At least 10 business days prior to the expiration of the license of a rehabilitation hospital, an applicant for renewal of that licensure shall submit to the Department:

1. The completed form of application for renewal of licensure transmitted to the applicant pursuant to (b) above;

2. A non-refundable fee of $10,000 for the issuance of the renewed license; and

3. If applicable in that year, a non-refundable biennial inspection fee of $5,000 for the review of the licensure application.

(e) The inspection fee shall not be due more frequently than biennially, even if inspections occur more or less frequently than biennially.

(f) The Department may renew, annually, a license on the original licensure date or within 30 days thereafter but dated as of the original licensure date; provided:

1. The expiring license is in good standing, that is, it has not been suspended or revoked;

2. The licensee has not been charged with a violation of Federal, State, or local law with regard to the operation of the rehabilitation hospital; and

3. The Department receives the following from the applicant for renewal of licensure:

i. The applicable license renewal fee;

ii. The licensee's regulatory compliance statement in accordance with N.J.S.A. 26:2H-1 et seq.;

(1) A written attestation on facility letterhead, signed by a facility's chief executive officer, stating that the facility is in compliance with the requirements of this chapter and that the facility will continue to remain in compliance during the term of the license;

(2) A copy of documentation of a facility's certification by or accreditation from an accrediting body recognized by the Centers for Medicare & Medicaid Services of the U.S. Department of Health and Human Services; and

(3) Upon request of the Licensing Office, a copy of the accrediting body's most recent report of its survey of the facility and recommendations for corrective actions, and a progress report of all corrective actions the facility has taken in response to the accreditation body's report; and

iii. If applicable that year, the biennial inspection fee.

(g) If a licensee fails to renew its license and continues to operate the rehabilitation hospital, this shall constitute the operation of a rehabilitation hospital without a license and may result in issuance by the Department of a cease-and-desist order, in accordance with N.J.A.C. 8:43E-3.11 and other penalties in accordance with N.J.A.C. 8:43E-3.4(a).

(h) An applicant denied a license to operate a rehabilitation hospital shall have the right to a fair hearing in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

8:43H-2.7 Surrender of license

(a) Except as set forth in this section, a license shall be immediately void if:

1. The rehabilitation hospital ceases to provide services;

2. Ownership of the rehabilitation hospital changes without Department approval in accordance with N.J.A.C. 8:43H-2.8; or

3. The location of the rehabilitation hospital changes without prior Department approval.

(b) If a licensed rehabilitation hospital intends to cease operations, the licensee may request the Department to maintain the license for a period of up to 24 months, and the Department may grant the request, provided the licensee makes the request at least 60 days prior to ceasing operations, and the request contains the rationale for the maintenance of the license following cessation of operations and the period during which the licensee requests the Department to maintain the license.

8:43H-2.8 Transfer of ownership

(a) A license shall not be assignable or transferable and shall be immediately void if the hospital ceases to operate, if its ownership changes, or if it is relocated to a different site.

(b) A representative of the hospital shall notify the Department of any change in the ownership form or controlling interests affecting hospital governance. The Department shall determine whether a certificate of need or licensing application must be completed prior to the implementation of any ownership changes based upon the information filed and the criteria at N.J.A.C. 8:33-3.3.

(c) A transfer of ownership of a rehabilitation hospital shall include the following:

1. A description of the proposed transfer of ownership, in detail, including total purchase cost;

2. Identification of 100 percent of the existing and prospective owners of the physical assets of the rehabilitation hospital;

3. Identification of 100 percent of the existing and prospective operators of the rehabilitation hospital; and

4. If applicable, identification of 100 percent of the existing and prospective ownership of leased buildings and property comprising the rehabilitation hospital.

(d) Upon approval by the Department, the prospective owner shall transmit to the Department a copy of all legal documents pertaining to the transfer of ownership transaction executed by the parties within seven business days following the consummation or closure of the transfer of ownership transaction to include the transfer of ownership agreement and facility licensure application.

8:43H-2.9 Newly constructed or expanded facilities

(a) Any comprehensive rehabilitation hospital with a reconstruction, expansion, or construction program for review and approval, prior to the initiation of the reconstruction, expansion, or construction project shall submit final construction documents plans to:

Health Care Plan Review Unit

Division of Codes and Standards

New Jersey Department of Community Affairs

PO Box 817

Trenton, New Jersey 08625-0815

Telephone: 609-633-8151

http://www.nj.gov/dca/codes/offices/ePlans.shtml

(b) Prior to submitting final construction documents in accordance with (a) above, an applicant for a license to operate a comprehensive rehabilitation hospital may request that the Certificate of Need and Healthcare Facility Licensure Program (Program) schedule an appointment to conduct a functional review of the proposed project to review the conditions for licensure and operation, which request the Program shall grant.

(c) A newly constructed, reconstructed, or expanded comprehensive rehabilitation hospital shall conform with the New Jersey Uniform Construction Code, N.J.A.C. 5:23-3, Use Group I-2 of the subcode.

1. The licensure application for a newly constructed, reconstructed, and expanded rehabilitation hospital shall include written approval of final construction of the physical plant by the Health Care Plan Review Unit, Division of Codes and Standards, New Jersey Department of Community Affairs, in accordance with this chapter.

(d) A copy of the certificate of occupancy issued by the local municipality shall be submitted to the Health Care Plan Review Unit and to the Certificate of Need and Healthcare Facility Licensure Program prior to licensure or approval of newly constructed, reconstructed, or expanded comprehensive rehabilitation hospital.

1. Reconstruction does not include any type of renovation.

8:43H-2.10 Licensed rehabilitation hospital survey

(a) Regardless of whether a rehabilitation hospital participates in and receives payment from the Medicare or Medicaid programs and is certified as complying with the Conditions of Participation (CoPs), or standards set forth in Federal regulations, the authorized staff of the DHFSFO may survey the rehabilitation hospital at any time.

(b) N.J.A.C. 8:43E-2 shall govern the processes by which the Department conducts surveys, identifies deficiencies, resolves disputes, and reviews plans of correction for rehabilitation hospitals.

8:43H-2.11 Waiver of licensing standards

(a) The Commissioner, or his or her designee, in accordance with N.J.S.A. 26:2H-1 et seq., and this chapter, may waive provisions of this chapter if, in their opinion, such waiver would not endanger the life, safety, or health of patients, and would not render the premises, equipment, personnel, finances, rules, by-laws, and standards of health care at a rehabilitation hospital unfit or inadequate.

1. A rehabilitation hospital seeking an “application for a waiver” of any rule in this chapter shall apply, in writing, to the Director of the Office of Certificate of Need and Healthcare Facility Licensure of the Department. Application for Waiver, form number CN-28, is available on the Department’s website at www.nj.gov/health/forms.

2. A written request for a waiver shall include the following:

i. A citation to the specific rule or part of the rule for which a waiver is requested;

ii. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the rehabilitation hospital upon adherence;

iii. An alternative proposal that would ensure the care and safety of the patients in the rehabilitation hospital; and

iv. Documentation to support the request for a waiver.

3. The Department may request additional information before processing a request for waiver.

4. A waiver request that does not conform to (a)2 above may be rejected for processing by the Department.

8:43H-2.12 Action against a licensee

(a) Pursuant to N.J.S.A. 26:2H-1 et seq., the Commissioner may impose all enforcement actions permitted pursuant to N.J.A.C. 8:43E and any other relevant statutes and rules for violation of this chapter or other laws.

(b) Enforcement actions include civil monetary penalty, curtailment of admissions, the appointment of a receiver, revocation of a license, order to cease and desist operation of an unlicensed rehabilitation hospital, and other remedies for violations of law.

8:43H-2.13 Advertisement of comprehensive acute rehabilitation hospital services

(a) An entity that is not licensed as a rehabilitation hospital shall not describe, or offer itself to the public, as providing intensive comprehensive rehabilitation hospital services or acute rehabilitation services.

(b) Violation of this section constitutes operation of a rehabilitation hospital without a license and is subject to penalty imposition in accordance with N.J.S.A. 26:2H-14.

8:43H-2.14 Duty to update information

Whenever any information included in a license or renewal application changes, the licensee shall provide that information to the Office of Certificate of Need and Healthcare Facility Licensure, in writing, within 10 calendar days of the change.

8:43H-2.15 Rehabilitation hospital satellite facilities and off-site ambulatory care service facilities

(a) A satellite hospital facility may be operated pursuant to the effective supervision of an existing rehabilitation hospital.

(b) Individual licenses shall not be required for separate hospital buildings and services located on the same or adjoining grounds if these are operated under one management.

(c) All off-site ambulatory care service facilities, including mobile units, must be licensed to operate by the Department. A rehabilitation hospital may seek licensure and classification of off-site ambulatory care service facilities as either "free-standing" or "hospital-based" facilities.

(d) Both "free-standing" and "hospital-based" off-site ambulatory care service facilities shall be separately inspected and separately licensed in accordance with the provisions set forth at N.J.A.C. 8:43A, Standards for Licensure of Ambulatory Care Facilities.

(e) All off-site ambulatory care service facilities are presumed to be "free-standing."

(f) A rehabilitation hospital seeking licensure and classification of an off-site ambulatory care service facility as "hospital-based" shall so indicate on the CN-7 licensure application available on the Department's website at www.nj.gov/health/forms and shall provide documentation of the following:

1. The hospital-based off-site ambulatory care service facility is integrated with, and subordinate and accountable to, the rehabilitation hospital. Services provided at the off-site location are clinically integrated with other departments of the rehabilitation hospital and staff members who are employees of the rehabilitation hospital. Where applicable, credentialing of hospital-based ambulatory care service facility staff is performed by the rehabilitation hospital credentialing committee. Where applicable, the hospital-based ambulatory care service facility is required to comply with the provisions set forth at N.J.A.C. 8:43G-4.1, Patient rights.

2. The rehabilitation hospital-based ambulatory care service facility administrator is subordinate to, and reports to, an identified administrator at the rehabilitation hospital. The rehabilitation hospital chief medical officer (or similar official) is also responsible for the medical direction of the hospital-based ambulatory care service facility.

3. If the rehabilitation hospital is accredited, the hospital-based ambulatory care service facility is included in the accreditation and the accrediting body recognizes the hospital-based ambulatory care service facility as part of the rehabilitation hospital.

4. The hospital-based off-site ambulatory care service facility is operated under common ownership and control and by the same governing authority as the rehabilitation hospital. The factors considered in evaluating this criterion are one or more of the following:

i. The hospital-based ambulatory care service facility and the rehabilitation hospital are subject to common bylaws and operating decisions of the governing authority;

ii. Final responsibility for administrative decisions, personnel actions, and approval of hospital-based ambulatory care service facility medical staff appointments rests with the rehabilitation hospital;

iii. The hospital-based ambulatory care service facility functions as a department of the rehabilitation hospital; and/or

iv. The hospital has written policies, procedures, and protocol applicable to the hospital-based ambulatory care service facility, ensuring that the requirements of this section are followed.

5. The director of the hospital-based ambulatory care service facility must function pursuant to the day-to-day operation of the rehabilitation hospital. The factors considered in evaluating this criterion are one or more of the following:

i. The hospital-based ambulatory care service facility director (or the individual responsible for the day-to-day operation of the hospital-based ambulatory care service facility) reports daily and is accountable to the chief executive officer of the rehabilitation hospital and also reports to the rehabilitation hospital authority through the chief executive officer;

ii. Medical records, billing, laundry, housekeeping, purchasing, and all other administrative functions of the hospital-based ambulatory care service facility are integrated with those of the rehabilitation hospital; and/or

iii. The rehabilitation hospital has written policies, procedures, and protocols applicable to the hospital-based ambulatory care service facility, ensuring that the requirements of this section are followed.

6. All hospital-based ambulatory care service facility clinical services are integrated with those of the rehabilitation hospital. The factors considered in evaluating this criterion are one or more of the following:

i. Hospital-based ambulatory care service facility professional staff have clinical privileges in the rehabilitation hospital;

ii. Where applicable, the hospital-based ambulatory care service facility medical director reports to the chief medical officer (or similar official) of the rehabilitation hospital;

iii. All rehabilitation hospital medical staff and other professional committees are responsible for all medical activities at the hospital-based ambulatory care service facility;

iv. Medical records for patients treated in the hospital-based ambulatory care service facility are integrated into the unified records system of the rehabilitation hospital;

v. Patients treated at the hospital-based ambulatory care service facility are considered patients of the rehabilitation hospital and have full access to all rehabilitation hospital services;

vi. Patient services provided at the hospital-based ambulatory care service facility are integrated with corresponding rehabilitation hospital inpatient and/or outpatient services, as appropriate; and/or

vii. The rehabilitation hospital has written policies, procedures, and protocols applicable to the hospital-based ambulatory care service facility, ensuring that the requirements of this section are followed.

7. The hospital-based ambulatory care service facility is held out to the public as part of the rehabilitation hospital, such that patients know they are entering the rehabilitation hospital and will be billed accordingly.

8. The rehabilitation hospital and the hospital-based ambulatory care service facility are financially integrated. The factors considered in evaluating this criterion are one or more of the following:

i. The rehabilitation hospital and the hospital-based ambulatory care service facility have a written agreement for the sharing of income and expenses; and/or

ii. The hospital-based ambulatory care service facility reports its costs, including total revenues and total expenses, as part of the rehabilitation hospital's audited financial statements and uses the same accounting system for the same cost reporting period as the rehabilitation hospital.

9. The hospital-based ambulatory care service facility accepts and provides care to patients and accordingly, shall not deny admission to patients based on their inability to pay.

SUBCHAPTER 3. SERVICES, PERSONNEL, POLICY, AND PROCEDURE MANUAL REPORTING

8:43H-3.1 Rehabilitation hospital services

(a) A rehabilitation hospital shall provide intensive comprehensive rehabilitation therapy in an inpatient hospital environment for patients that require and can be expected to benefit from an inpatient stay while utilizing an interdisciplinary team approach for care and in accordance with N.J.A.C. 8:43H-11.1, which shall include:

1. Occupational therapy;
2. Physical therapy;
3. Speech-language; or
4. Orthotics/prosthetics.

(b) A rehabilitation hospital shall make available on an inpatient basis as ordered by a rehabilitation physician and as part of the plan of care in the following services:

1. Dietary;
2. Laboratory;
3. Medical;
4. Nursing;
5. Nutritional counseling;
6. Pharmaceutical;
7. Physiatry; and
8. Social work.

(c) The following therapies may be provided, if the medical necessity is documented by the rehabilitation physician in the medical record and is ordered by the rehabilitation physician as part of the plan of care for the patient:

1. Music therapy;
2. Recreational therapy;

3. Respiratory therapy; and

4. Psychological services.

(d) The following services may be provided outside the rehabilitation hospital at an off-site location, subject to all applicable licensing rules:

1. Audiology;

2. Dental;

3. Driver evaluation and training;

4. Environmental assessment;

5. Radiological; and

6. Vocational services.

(e) A rehabilitation hospital shall not admit patients that are not capable of participating in and benefitting from intensive comprehensive rehabilitation services in accordance with all Federal and State requirements.

(f) Upon admission, a rehabilitation physician shall conduct face-to-face visits with the patient at least three days per week throughout the patient's stay in the rehabilitation hospital to:

1. Assess the patient both medically and functionally; and

2. To modify the course of treatment, as needed.

8:43H-3.2 Ownership of rehabilitation hospital

A rehabilitation hospital shall disclose the ownership of the rehabilitation hospital and the property on which it is located to the Department. Proof of this ownership shall be immediately available upon request. Any change of ownership shall be reported to

the Department, in writing, at least 30 days prior to the change and in conformance with the requirements for the certificate of need applications at N.J.A.C. 8:43H-2.5.

8:43H-3.3 Personnel

(a) A rehabilitation hospital shall establish written job descriptions and ensure that personnel are assigned duties based upon their education, training, and competencies, and in accordance with their job descriptions.

(b) A rehabilitation hospital shall ensure that all personnel who require licensure, certification, or authorization to provide patient care shall be licensed, certified, or authorized pursuant to the appropriate Federal laws or rules of the State of New Jersey.

(c) A rehabilitation hospital shall maintain written staffing schedules and shall provide for substitute staff with equivalent qualifications to replace absent staff members.

1. A rehabilitation hospital shall implement staffing schedules to ensure continuity of care and the provision of services consistent with the rehabilitation goals specified in the patient treatment plan.

(d) A rehabilitation hospital shall develop and implement staff orientation and a staff education plan, designate a person(s) responsible for training, and shall ensure that:

1. All personnel shall receive orientation at the time of employment and continuing in-service education regarding emergency plans and procedures, and the infection prevention and control services;

2. At least one education training program each year shall be held for all administrative staff and employees providing resident supervision and/or personal care on the rehabilitation hospital’s policies and procedures implementing patient rights and

responsibilities of staff pursuant to the New Jersey Advance Directives for Health Care Act, N.J.S.A. 26:2H-53 et seq.; and

3. At least one education training program each year shall be held for all administrative staff and employees providing resident supervision and/or personal care on the rights and responsibilities of staff pursuant to the Practitioner Orders for Life-Sustaining Treatment Act in accordance with N.J.S.A. 26:2H-129 et seq.

(e) A rehabilitation hospital shall ensure that at least one person trained in cardiopulmonary resuscitation in an approved certification course, as defined in the rehabilitation hospital's policy and procedure manual, is present in all patient areas when patients are present.

8:43H-3.4 Policies and procedures manual

(a) A rehabilitation hospital shall develop, implement, and review the policies and procedures manual for the organization and operation of the rehabilitation hospital.

1. A rehabilitation hospital shall document each review of the manual and shall make the manual available in the rehabilitation hospital to representatives of the Department at all times.

(b) A rehabilitation hospital's policy and procedure manual shall contain at least the following:

1. A written statement of the objectives of and the services provided by the rehabilitation hospital;

2. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and patient care services of the rehabilitation hospital;

3. A description of the quality improvement program for patient care and staff performance;

4. The business and visiting hours of the rehabilitation hospital;

5. Policies and procedures for reporting actual and suspected cases of child abuse and/or neglect in compliance with N.J.S.A. 9:6-8 et seq., particularly addressing:

i. The designation of a staff member to be responsible to coordinate the reporting of actual and suspected cases of child abuse and/or neglect, documenting in the medical record the issuance of the report to the applicable governmental agency with jurisdiction in accordance with applicable law, and serving as a liaison between the rehabilitation hospital and the applicable governmental agency with jurisdiction;

ii. The development of written protocols for the identification and treatment of abused and/or neglected children; and

iii. The provision of education and/or training programs on at least an annual basis to appropriate persons regarding the identification and reporting of actual and suspected cases of child abuse and/or neglect and regarding the rehabilitation hospital’s policies and procedures;

6. Policies and procedures developed in accordance with N.J.A.C. 8:43H-5.3 and 5.4 for implementing advance directives;

7. Policies and procedures developed in accordance with N.J.A.C. 8:43H-5.5 for implementing the POLST form;

8. Policies and procedures governing patient transportation to off-site services, including emergency services, addressing plans for the security of and accountability for patients and their possessions during transport;

9. Policies and procedures implementing the responsibilities of the rehabilitation hospital, physicians, and other staff in conformance with applicable law, including N.J.S.A. 26:6 and 26:6A, and rules of the New Jersey State Board of Medical Examiners;

10. Policies and procedures, including content and frequency, for physical examinations upon employment and subsequently for employees and persons providing direct patient care services through contractual arrangements or written agreements in accordance with N.J.A.C. 8:43G-20;

11. Policies and procedures by which the rehabilitation hospital shall have available and comply with the infection control guidelines listed at N.J.A.C. 8:43G-14.1;

12. Sepsis protocols and procedures in accordance with the requirements at N.J.A.C. 8:43G-14.9; and

13. Policies and procedures for identifying human trafficking in accordance with N.J.A.C. 8:43E-14.

(c) The policies and procedures manual may contain the policies and procedures for patient care standards required pursuant to N.J.A.C. 8:43H-6.1.

(d) The policies and procedures shall be reviewed annually, revised, and implemented.

8:43H-3.5 Contractual agreements

(a) A rehabilitation hospital shall have written agreements in place for services provided by contract or subcontracts that:

1. Are dated and signed by a representative of the rehabilitation hospital and by the entity providing the service or its authorized representative;

2. Specify each party's responsibilities, functions, and objectives, the time during which services are to be provided, the financial arrangements and charges, and the duration of the written agreement or its equivalent;

3. Specify that the rehabilitation hospital shall retain administrative responsibility for services rendered, including subcontracted services;

4. Require the contractor or subcontractor to provide services in accordance with this chapter;

5. Require personnel providing contracted or subcontracted services to:

i. Meet training and experience requirements;

ii. Be supervised in accordance with this chapter; and

iii. Be responsible for following the policies and procedures of the facility; and

6. Require the contractor or subcontractor to submit to the rehabilitation hospital written documentation of provided services within seven working days of execution of the contract including, but not limited to, documentation of services rendered by the person or agency providing the service.

(b) A rehabilitation hospital shall be responsible for services furnished in the hospital by outside entities pursuant to contractual agreements. The rehabilitation hospital shall

ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable codes and regulations.

1. A rehabilitation hospital shall ensure that the services performed pursuant to a contractual agreement are provided safely and effectively, in accordance with the requirements of this chapter.

2. A rehabilitation hospital shall maintain a list of all contracted services, including the scope and nature of services provided.

8:43H-3.6 Reportable events

A rehabilitation hospital shall comply with the requirements of the Patient Safety Act, N.J.S.A. 26:2H-12.23 through 12.25, and the Rules Implementing Patient or Resident Safety Requirements and Reportable Events at N.J.A.C. 8:43E-10.

8:43H-3.7 Posted notices

(a) A rehabilitation hospital shall conspicuously post a notice that the following information is available in the facility during the regular business hours to patients and the public:

1. All waivers granted by the Department;

2. All documents required pursuant to this chapter;

3. A list of rehabilitation hospital committees, or their equivalents, and the membership of each; and

4. Policies and procedures regarding patient rights.

(b) A rehabilitation hospital shall maintain on file in the administrator's office, the following information for any interested party to review:

1. The names and business addresses of members of the governing authority; and

2. A rehabilitation hospital shall report any changes or membership of the governing authority, within 30 days after the change.

8:43H-3.8 Reporting information to clearing house coordinator and State Board of Medical Examiners

A rehabilitation hospital shall comply with the requirements of the Rules Implementing the Health Care Professional Responsibility and Reporting Enhancement Act at N.J.A.C. 8:30.

8:43H-3.9 Financial reports

A rehabilitation hospital shall adopt and maintain the Centers for Medicare and Medicaid Services system of cost reporting required by 42 CFR Part 412, Medicare Program; Facility Prospective Payment Systems for Inpatient Rehabilitation Hospitals and Rehabilitation Units, from which reports shall be prepared by the licensee to meet the requirements of the Commissioner in accordance with N.J.S.A. 26:2H-1 et seq.

SUBCHAPTER 4. REHABILITATION HOSPITAL GOVERNING AUTHORITY

8:43H-4.1 Responsibility of the governing authority

(a) A rehabilitation hospital shall have a governing authority that shall assume legal responsibility for the management, operation, and financial viability of the rehabilitation hospital. The governing authority shall be responsible for, but not limited to, the following:

1. Services provided, and the quality of care rendered to patients;

2. Provision of a safe physical plant equipped and staffed to maintain the rehabilitation hospital and services;

3. Adoption and documented review of written bylaws, or their equivalent, according to a schedule established by the governing authority;

4. Appointment, reappointment, assignment of privileges, and curtailment of privileges of health care professionals, and written confirmation of such actions;

5. Development and documented review of all policies and procedures, according to a schedule established by the governing authority;

6. Establishment and implementation of a system whereby patient and staff grievances and/or recommendations, including those relating to patient rights, can be identified within the rehabilitation hospital. This system shall include a feedback mechanism through management to the governing authority, indicating what action was taken;

7. Determination of the frequency of meetings of the governing authority and its committees, or their equivalents, conducting such meetings, and documenting them through minutes;

8. Delineation of the duties of the officers of any committees, or their equivalent, of the governing authority. When the governing authority establishes committees or

their equivalents, their purpose, structure, responsibilities, and authority, and the relationship of the committee or its equivalent to other entities within the rehabilitation hospital shall be documented;

9. Establishment of the qualifications of members and officers of the governing authority, the procedures for electing and appointing officers, and the terms of service for members, officers, and committee chairpersons or their equivalents; and

10. Approval of the medical staff bylaws or their equivalent.

SUBCHAPTER 5. ADMINISTRATION

8:43H-5.1 Appointment of chief executive/administrator

(a) The governing authority shall appoint a chief executive/administrator accountable for rehabilitation services who shall be available to the rehabilitation hospital at all times.

(b) An alternate shall be designated, in writing, to act in the absence of the chief executive/administrator accountable for rehabilitation services.

8:43H-5.2 Chief executive/administrator's responsibilities

(a) The chief executive / administrator shall be responsible for, but not limited to, the following:

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

2. Planning for, and administration of, the managerial, operational, fiscal, and reporting components of the rehabilitation hospital;

3. Participating in the quality improvement program for patient care and staff performance;

4. Ensuring that all personnel are assigned duties based on their education, training, competencies, and job descriptions;

5. Ensuring the provision of staff orientation and staff education; and

6. Establishing and maintaining liaison relationships, communication, and integration with rehabilitation hospital staff and services and with patients and their responsible persons.

8:43H-5.3 Advance directive dispute resolution; a forum for discussion; community education

(a) A rehabilitation hospital shall establish procedures for considering disputes among the patient, the health care representative, and the attending physician concerning the patient's decision-making capacity or the appropriate interpretation and application of the terms of an advance directive to the patient'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 make clinical and ethical judgments.

(b) A rehabilitation hospital shall establish a process for patients, responsible persons, healthcare representatives, and staff to discuss and address questions and concerns relating to advance directives and decisions to accept or reject medical treatment.

(c) A rehabilitation hospital 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 pursuant to New Jersey law to execute advance directives.

8:43H-5.4 Advance directives

(a) A rehabilitation hospital shall develop and implement procedures to ensure that there is a routine inquiry made of each adult patient, upon admission to the rehabilitation hospital and at other appropriate times, concerning the existence and location of an advance directive.

(b) If the patient is incapable of responding to this inquiry, the rehabilitation hospital shall have procedures to request the information from the responsible person or, in the absence of a responsible person, a healthcare representative or another individual with personal knowledge of the patient. The procedures shall ensure that the patient or responsible person's response to this inquiry is documented in the medical record. Such procedures shall also define the role of rehabilitation hospital admissions, nursing, social services, and other staff, as well as the responsibilities of the attending physician.

(c) A rehabilitation hospital shall develop and implement procedures to promptly request and take reasonable steps to obtain a copy of currently executed advance directives from all patients. These shall be entered when received into the medical record of the patient.

(d) A patient may be transferred by a rehabilitation hospital to another health care facility in accordance with N.J.A.C. 8:43G-4.1(a)15 or in conformance with the New

Jersey Advance Directives for Health Care Act in the instance of private, religiously affiliated health care institutions that establish policies defining circumstances in which it will decline to participate in the implementation of advance directives. Such institutions shall provide notice to patients or their responsible persons or health care representatives prior to or upon admission of their policies. A timely and respectful transfer of the individual to another institution that will implement the patient's advance directive shall be affected. The sending facility shall receive approval from a physician and the receiving healthcare facility before transferring the patient.

(e) A rehabilitation hospital shall, in consultation with the attending physician, take all reasonable steps to affect the appropriate, respectful, and timely transfer of patients with advance directives to the care of an alternative healthcare professional in those instances where a healthcare 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 patient's physician, the rehabilitation hospital shall take reasonable steps, in cooperation with the physician, to transfer the patient to another physician's care in a responsible and timely manner. Such transfer shall ensure that the patient's advance directive is implemented in accordance with their wishes within the rehabilitation hospital, except in cases governed pursuant to (c) above.

(f) A rehabilitation hospital shall have procedures to provide each adult patient upon admission and, where the patient is unable to respond, to the responsible person or other representative of the patient, with a written statement of their rights pursuant to New Jersey law to make decisions concerning the right to refuse medical care and the

right to formulate an advance directive. Appropriate written information and materials on advance directives and the institution's written policies and procedures concerning the implementation of such rights shall also be provided. Such written information shall also be made available in any language that is spoken, as a primary language, by more than 10 percent of the population served by the rehabilitation hospital.

(g) A rehabilitation hospital shall develop and implement procedures for referral of patients 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 patient.

(h) A rehabilitation hospital shall develop and implement policies to address the application of the facility's procedures for advance directives to patients who experience an urgent, life-threatening situation.

(i) A rehabilitation hospital shall develop and implement policies and procedures for the declaration of the death of patients, in instances, where applicable, in accordance with N.J.S.A. 26:6 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 at N.J.A.C. 13:35-6A, which address the declaration of death based on neurological criteria, including the qualifications of physicians authorized to declare death based on neurological criteria and the acceptable medical criteria, tests, and procedures which may be used. The policies and procedures shall also accommodate a patient's religious beliefs concerning the declaration of death.

8:43H-5.5 Requirements for practitioner orders for life-sustaining treatment (POLST)

(a) A rehabilitation hospital shall comply with the requirements of the Practitioner Orders for Life-Sustaining Treatment Act (POLST Act), N.J.S.A. 26:2H-129 et seq.

(b) A rehabilitation hospital shall establish, review at least annually, and more often, as needed, revise, as needed, and implement, written policies and procedures to effectuate the POLST Act, that include, but are not limited to:

1. The requirements imposed upon agencies at N.J.S.A. 26:2H-134;

2. Procedures in the event of a disagreement regarding a POLST Form in compliance with N.J.S.A. 26:2H-136; and

3. A delineation of the responsibilities of attending practitioners, administration, nursing, social service, and other staff regarding the POLST Form.

(c) Before providing care to an adult patient, and routinely thereafter at other appropriate times, the rehabilitation hospital shall:

1. Inquire of the patient, the responsible person, or another patient representative if the patient is unable to respond, about the existence and location of an advance directive for the patient;

2. Document each response to this inquiry in the patient’s medical record;

3. If this inquiry indicates that a POLST Form for the patient exists and is in effect, request and take reasonable steps to obtain the POLST Form;

4. Enter the POLST Form into the patient’s medical record; and

5. In conformance with the POLST Act, in the instance of a private, religiously affiliated rehabilitation hospital that establishes written policies defining circumstances in

which it will decline to participate in the withholding or withdrawal of life-sustaining treatment, such rehabilitation hospitals shall:

i. Provide written notice of the policy to patients, responsible persons, or health care representatives before or at the time of admission to services;

ii. Implement a timely and respectful transfer of the patient to a facility that will implement the POLST Form; and

iii. The sending facility shall receive approval from the receiving facility before transferring the patient.

8:43H-5.6 Policies and procedures for admission of a pediatric patient of at least 16 years of age to an adult rehabilitation hospital

(a) An adult rehabilitation hospital shall adhere to the following process to admit a pediatric patient who is at least 16 years of age and under 18 years of age, to the adult rehabilitation hospital:

1. If the adult rehabilitation hospital receives a referral of a pediatric patient who is at least 16 years of age, the adult rehabilitation hospital shall:

i. Instruct the referral source to refer the patient in the first instance to a pediatric rehabilitation hospital; and

ii. Notify the pediatric rehabilitation hospital in the geographic location closest to the patient that referral of the patient is being made concurrently to both the pediatric and adult rehabilitation hospitals;

2. Within 24 hours of the pediatric rehabilitation hospital receiving a referral of the patient, the pediatric rehabilitation hospital shall conduct a review of clinical and

psychosocial information related to the patient and notify the adult rehabilitation hospital whether it recommends admission of the patient to the adult rehabilitation hospital;

3. If this process is conducted and does not result in a favorable recommendation(s) for admission to the adult rehabilitation hospital, the patient has the right to be admitted to the adult facility, nonetheless;

4. An adult rehabilitation hospital shall not admit patients who are under 16 years of age; and

5. An adult rehabilitation hospital may admit a pediatric patient who is at least 16 years of age and under 20 years of age, provided that, for patients ages 16 or 17, the hospital notifies the patient's parent or legal guardian, and for patients ages 18 and 19, the hospital notifies the patient, of the availability of a pediatric rehabilitation hospital that can admit the patient and the parent or guardian, or patient, as applicable, consents to the patient's admission to the adult facility.

i. The hospital shall document its issuance of the notice to the parent or guardian, or patient if 18 or 19 years of age, and whether the parent or guardian consents.

8:43H-5.7 Policies and procedures for admission of an adult patient to a pediatric rehabilitation hospital

(a) In order to admit a patient 20 years of age or older to a pediatric rehabilitation hospital, the following process shall be followed:

1. If the pediatric rehabilitation hospital receives a referral of a patient 20 years of age or older, the pediatric rehabilitation hospital shall advise the referral source that the patient must first be referred to an adult rehabilitation hospital.

i. The pediatric rehabilitation hospital shall also contact the adult rehabilitation hospital in the geographic location closest to the patient to advise it that such a referral is also being made for pediatric rehabilitation services;

2. For the pediatric rehabilitation hospital to proceed with admitting the patient, it shall receive, within 24 hours of the referral, a recommendation from the adult rehabilitation hospital, based on its review of clinical and psychosocial information related to the patient, regarding the patient's admission to the pediatric rehabilitation hospital; and

3. If this process is conducted and does not result in a favorable recommendation(s) for admission to the pediatric rehabilitation hospital, the patient has the right to be admitted to the pediatric facility, and the pediatric rehabilitation facility shall accept the patient, nonetheless.

SUBCHAPTER 6. PATIENT CARE STANDARDS

8:43H-6.1 Policies and procedures

(a) A rehabilitation hospital shall establish and implement written patient care policies and procedures governing the services provided. Each review of the policies and procedures shall be documented. Policies and procedures shall include, but not be limited to, policies and procedures for the following:

1. Patient rights in accordance with N.J.A.C. 8:43G-4;

2. The determination of staffing levels based on patient acuity;

3. The referral of patients to other health care providers and medical consultative services;

4. The provision of sexual counseling services directly in the rehabilitation hospital, in accordance with the patient treatment plan;

5. The provision of consultation for environmental modification services in the patient's living environment, in accordance with the care plan as may be needed to permit maximum independent functioning;

6. Emergency care of patients;

7. Obtaining written informed consent;

8. Patient instruction and health education, including the provision of printed and/or written instructions and information for patients, with multilingual instructions as indicated;

9. Admission of patients;

10. Orientation for the patient and the patient's responsible person, conducted by the rehabilitation hospital's designated representative, before or at the time of the patient's admission.

i. The orientation shall include, at a minimum, the following: rehabilitation hospital policies, business hours, fees for services known at the time of admission, services provided, patient rights, and criteria for admission, treatment, and discharge; and

ii. Documentation of orientation shall be included in the patient's medical record;

11. Restrictions to the admission and retention of patients, to ensure that:

i. A patient who manifests a degree of behavioral disorder indicating that the patient is a danger to self or others, or whose behavior interferes with the health or safety of other patients, shall not be admitted or retained; and

ii. A patient with only a primary diagnosis of substance use disorder shall not be admitted to or retained in the rehabilitation hospital;

12. Telephone orders, to ensure that they are written into the patient's medical record by the person accepting them and countersigned by the prescriber within the time frame.

i. Verbal orders shall be limited to emergencies, as defined in the rehabilitation hospital's policies and procedures; and

ii. Verbal orders shall be verified or countersigned, in writing, as prescribed at N.J.A.C. 8:43G-16.2(a)4 and (b);

13. Financial arrangements, to ensure that the rehabilitation hospital:

i. Informs patients of the fees for services;

ii. Maintains a written record of all financial arrangements with the patient and/or responsible person, with copies furnished to the patient upon request;

iii. Assesses no additional charges, expenses, or other financial liabilities over the rehabilitation hospital's rate, except:

(1) Upon written approval and authority of the patient and/or the responsible person, who shall be given a copy of the written approval; or

(2) In the event of a health emergency involving the patient and requiring immediate, special services or supplies to be furnished during the period of the emergency;

iv. Consults with patients regarding insurance coverage and referral systems for patients' financial assistance; and

v. Describes sliding fee scales and any special payment plans established by the rehabilitation hospital;

14. Interpretation and communication services, as appropriate, to meet patient needs;

15. The prohibition of smoking in a facility in accordance with the New Jersey Smoke-Free Air Act, N.J.S.A. 26:3D-55 et seq.;

16. Except in the case of a competent adult, notification of the responsible person if the patient sustains an injury, immediately after the occurrence. In the event of an accident or incident that does not result in injury to the patient, notification of the responsible person is to occur within 24 hours of the occurrence. Immediately following such notification, the notification shall be documented in the patient's medical record;

17. The use of restraints, including at least the following:

i. Specification of the uses of restraints and types of restraints permitted, as well as of the use of alternatives to restraints such as staff or environmental interventions, structured activities, or behavior management. Alternatives shall be utilized whenever possible to avoid the use of restraints. The specific nature of the device used to restrain the patient does not in itself determine whether it is a restraint. Rather, it is the device's intended use, its involuntary application,

and/or the identified patient need that determines whether the device is a physical restraint. Therefore, this policy of requiring alternatives to restraints does not apply to:

(1) Standard practices that include limitation of mobility or temporary immobilization related to medical, dental, diagnostic, or surgical procedures and the related post-procedure care processes;

(2) Adaptive support in response to assessed patient needs (for example, postural support, orthopedic appliances, tabletop chairs, or bedrails);

(3) Helmets; or

(4) Therapeutic holding or comforting of patients;

ii. Prohibition of the use of locked restraints and confinement of a patient in a locked or barricaded room, and prohibition of the use of restraints for punishment or the convenience of rehabilitation hospital personnel;

iii. A delineation of indications for use, which should be limited to:

(1) Prevention of imminent harm to the resident or other persons when other means of control are not effective or appropriate; or

(2) Prevention of serious disruption of treatment or significant damage to the physical environment;

iv. Written protocols for:

(1) Informing the patient and obtaining consent, when clinically feasible, and documenting the consent in the patient’s record;

(2) Notifying the responsible person to obtain consent if the patient is unable to give consent and documenting the consent in the patient's record;

(3) Imposing restraints for a limited period and removing restraints when goals have been accomplished; and

v. A requirement that a physical restraint shall only be used when authorized, in writing, by a physician except when necessitated by an emergency, in which case it shall be approved by the medical director, the nurse accountable for the rehabilitation nursing service, or that professional's designee;

18. Discharge, transfer, and readmission of patients, including criteria for each:

i. Written notification by the administrator shall be provided to a patient of a decision to involuntarily discharge the patient from the rehabilitation hospital. The notice shall include the reason for discharge and the patient's right to appeal. A copy of the notice shall be entered in the patient's medical record; and

ii. The patient shall have the right to appeal to the administrator, any involuntary discharge from the rehabilitation hospital. The appeal shall be, in writing, and a copy shall be included in the patient's medical record with the disposition or resolution of the appeal;

19. The care and control of assistive animals (for example, seeing-eye dogs, service dogs), as well as the care and control of pets if the rehabilitation hospital permits pets in the rehabilitation hospital or on its premises;

20. The calibration of instruments of measurement, including the frequency of calibration; and

21. Care of deceased patients, including, but not limited to, the following:

i. Pronouncement of death, with notification to the responsible person by the physician at the time of death. The deceased shall not be discharged from the rehabilitation hospital until pronounced dead and the death documented in the patient's medical record;

ii. Removal of the deceased from rooms occupied by other patients; and

iii. Transportation of the deceased in the rehabilitation hospital, and removal from the rehabilitation hospital, in a dignified manner.

(b) The written policies and procedures required pursuant to this section may be maintained in the policies and procedures manual required at N.J.A.C. 8:43H-3.5 or may be maintained separately.

SUBCHAPTER 7. PREADMISSION ASSESSMENT; INTERDISCIPLINARY CARE PLANS

8:43H-7.1 Preadmission assessment

(a) Preadmission screenings shall be prepared in accordance with CMS regulations at 42 CFR 412.622.

(b) Any updates to the preadmission screening will be accepted within 48 hours and shall be provided in-person, or by telephone discussion to document the patient's medical and functional status prior to admission to the rehabilitation hospital.

(c) The preadmission screening shall serve as the primary documentation by the rehabilitation hospital clinical staff.

(d) Preadmission screening shall include the patient's current health status prior to admission to the rehabilitation hospital.

(e) Patients that are transferred from a referring hospital, the preadmission screening may occur in-person or through a review of the patient's medical records sent in paper format or electronic format and shall contain the necessary assessment.

(f) Certain elements of the preadmission screening may be evaluated by any licensed or certified clinician or team of clinicians designated by a rehabilitation physician.

(g) The preadmission screening shall include documentation to indicate the patient's:

1. Conditions that caused and require intensive comprehensive rehabilitation therapy;

2. The level of expected improvement;

3. Length of stay to achieve the expected level of improvement;

4. Any risk factors for clinical complications;

5. Type of rehabilitation treatments required, as follows:

i. Physical therapy;

ii. Occupational therapy;

iii. Speech-language pathology; or

iv. Orthotics/prosthetics; and

6. The anticipated discharge destination.

(h) The rehabilitation hospital shall have a screening process in place for a patient admitted from their home or community-based environment that should ensure that patient preadmission screening includes all the required elements described at 42 CFR 412.622.

1. Patients admitted to a rehabilitation hospital from home or a community-based setting may have medical records from a prior inpatient hospital.

(i) Rehabilitation hospitals shall determine their processes for collecting and compiling the preadmission screening information.

(j) The facility shall focus on completeness, accuracy, and appropriateness of the decision to admit a patient for comprehensive rehabilitation services.

(k) The rehabilitation physician shall document that preadmission screening has been reviewed and validate the decision to admit the patient for comprehensive rehabilitation services.

(l) All preadmission screening documentation (including documents transmitted from the referring hospital or other prior inpatient hospital stay, if applicable) must be retained in the patient's rehabilitation hospital medical record.

8:43H-7.2 Establishment of an interdisciplinary care plan

(a) A rehabilitation hospital shall develop an interdisciplinary care plan for each patient admitted by the rehabilitation hospital.

(b) The interdisciplinary care team shall meet every seven days, at a minimum, and shall be led by the rehabilitation physician.

(c) The rehabilitation physician responsible for providing care to the patient shall document in the patient's medical record admission and medical history, a report of a physical examination within 24 hours of admission, the plan of care, and progress notes.

(d) The rehabilitation physician shall participate as part of the interdisciplinary care team in implementing, reviewing, and revising the interdisciplinary care plan.

(e) The interdisciplinary care plan shall be initiated upon the patient's admission and completed within four days of admission. The interdisciplinary care plan shall include, but not be limited to:

1. The patient's treatment plan, which shall describe the care to be provided based upon the patient assessments;

2. An evaluation of the patient's potential for improving the patient's functional level and patient goals consistent with the patient's potential for rehabilitation; and

3. The patient's discharge plan.

(f) If the patient does not need a service, the interdisciplinary care plan need not include that service.

(g) A patient's treatment plan shall be developed from the assessments by the interdisciplinary care team and initiated upon the patient's admission. The patient treatment plan shall include, but not be limited to, the following:

1. Orders for treatment or services, medications, and diet;

2. The patient's rehabilitation goals for himself or herself;

3. The specific rehabilitation goals of treatment or services;

4. The time intervals, which shall not exceed seven days, at which the patient's response to treatment or services will be reviewed;

5. Anticipated time frame(s) for the accomplishment of the rehabilitation goals; and

6. The measures to be used by the interdisciplinary team to assess the effects of treatment or services, which shall include:

i. An evaluation of the patient's potential for improving the patient's functional level;

ii. Specific rehabilitation goals and timeframes consistent with the patient's potential for rehabilitation;

iii. Orders for treatment or services, medications, and diet; and

iv. The intervals (not to exceed seven days) at which the patient's response to treatment and progress toward stated goals or services will be reviewed.

(h) The patient and, if appropriate, responsible person shall participate in the development of the interdisciplinary care plan, including the discharge plan. Participation shall be documented in the patient's medical record.

(i) If, in the opinion of a physician, the patient's participation in the development of the interdisciplinary care plan is medically contraindicated, as documented in the patient's medical record, a designated member of the interdisciplinary care team shall review the interdisciplinary care plan with the patient before implementation and, if appropriate, the responsible person shall be informed of the interdisciplinary care plan.

8:43H-7.3 Implementation of the interdisciplinary care plan

(a) Each health care practitioner participating in the patient's care shall provide services in accordance with the interdisciplinary care plan.

(b) Each health care practitioner providing services to the patient shall establish criteria to measure the effectiveness and outcome of services provided and shall assess and reassess the patient to determine if services provided meet the established criteria.

1. Assessment and reassessment shall be documented in the patient medical record.

(c) Each discipline providing services to the patient shall participate as a member of the interdisciplinary team in developing, implementing, reviewing, and revising the interdisciplinary care plan.

1. The interdisciplinary care team shall review and revise the interdisciplinary care plan based upon the patient's response to the care provided by each of the participating services. Documentation in the patient's medical record shall indicate review and revision of the interdisciplinary care plan.

SUBCHAPTER 8. MEDICAL SERVICES

8:43H-8.1 Provision of medical services

A rehabilitation hospital shall provide medical services to all patients 24 hours a day, seven days a week, directly in the rehabilitation hospital.

8:43H-8.2 Appointment of medical director

A rehabilitation hospital shall appoint a medical director who shall provide services in accordance with rehabilitation hospital bylaws and policies. The medical director shall designate, in writing, a physician to act in the medical director's absence.

8:43H-8.3 Medical director's responsibilities

(a) The medical director is responsible for the direction, provision, and quality of medical services provided to patients, including:

1. Developing and maintaining written objectives, policies, the policy and procedure manual, an organizational plan, and a quality improvement program for the medical services;

2. Participating in planning and budgeting for the medical services;

3. Coordinating and integrating the medical services with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written responsibilities for the medical staff, and assigning duties based upon education, training, and competencies; and

5. Developing, implementing, and reviewing written medical policies in accordance with medical staff bylaws, or their equivalent, in cooperation with the medical staff, including, but not limited to, the following:

i. A plan for medical staff meetings and their documentation through minutes;

ii. A mechanism for establishing and implementing procedures relating to credentials review, delineation of qualifications, medical staff appointments and reappointments, evaluation of medical care, and the granting, denial, curtailment, suspension, or revocation of medical staff privileges; and

iii. A system for the completion of entries in the patient medical record by members of the medical staff. Entries shall be signed by a physician in accordance with the rehabilitation hospital's policies and procedures.

8:43H-8.4 Responsibilities of physicians

The physician who has primary responsibility to provide care to the patient shall document in the patient's medical record an admission medical history, a report of a physical examination within 24 hours of admission, and progress notes, and shall directly participate as part of the interdisciplinary team in developing, implementing, reviewing, and revising the interdisciplinary care plan.

8:43H-8.5 Availability of pediatrician

If the rehabilitation hospital provides care for pediatric patients, a pediatrician shall be available to provide treatment to the pediatric patient.

8:43H-8.6 Availability of pediatric rehabilitation physician

If the medical director of a rehabilitation hospital providing services to pediatric patients is a pediatrician, the pediatrician shall be a rehabilitation physician or a rehabilitation physician shall be available, in accordance with medical bylaws and rehabilitation hospital policies and procedures.

SUBCHAPTER 9. NURSING SERVICES

8:43H-9.1 Provision of nursing services

(a) A rehabilitation hospital shall provide nursing services to patients 24 hours a day, seven days a week, directly in the rehabilitation hospital facility.

(b) A rehabilitation hospital shall assign at least two licensed nurses, at least one of whom is a registered professional nurse, excluding the director of nursing services, or designee, to each nursing unit 24 hours a day, seven days a week.

1. Additional licensed nursing personnel and unlicensed assistive personnel shall be provided in accordance with the rehabilitation hospital's patient care policies and procedures for determining staffing levels based on the acuity of patient needs.

(c) A registered professional nurse who is eligible to be certified by the Association of Rehabilitation Nurses shall develop, supervise, and assess the staff orientation and staff education provided to nursing personnel by a rehabilitation hospital.

(d) A rehabilitation hospital, under the direction of the nursing services department, shall develop and adopt a curriculum for training unlicensed assistive personnel.

8:43H-9.2 Appointment of nursing leader accountable for the rehabilitation nursing services

(a) A rehabilitation hospital shall appoint, in writing, a nursing leader who shall be accountable for the rehabilitation nursing services and who shall be available at all times.

(b) A registered professional nurse shall be designated, in writing, to act in the nursing leader's absence.

8:43H-9.3 Responsibilities of nursing leader accountable for rehabilitation nursing services

(a) The nursing leader who is accountable for the rehabilitation nursing services is responsible for the direction, provision, and quality of nursing services provided to patients, including:

1. Developing and implementing written objectives, philosophy, policies, a procedure manual, an organizational plan, and participating in the rehabilitation hospital's quality improvement program;

2. Participating in planning and budgeting for the nursing services;

3. Coordinating and integrating the nursing services with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for nursing and unlicensed assistive personnel, and assigning job duties based upon education, training, continued competencies, and job descriptions;

5. Ensuring that nursing services are provided to the patient, as specified in the interdisciplinary care plan, which shall be initiated upon the patient's admission, and that nursing personnel are assigned to patients in accordance with the rehabilitation hospital's patient care policies and procedures for determining staffing levels based on the acuity of patient need; and

6. Providing for a planned orientation program in rehabilitation nursing concepts.

8:43H-9.4 Responsibilities of licensed nursing personnel

(a) In accordance with the State of New Jersey Nursing Practice Act, N.J.S.A. 45:11-23 et seq., and rules that the New Jersey State Board of Nursing promulgates pursuant

thereto, and written job descriptions, a rehabilitation hospital's licensed nursing personnel shall provide nursing care, including:

1. Care of patients through health promotion, maintenance, and restoration;

2. Care to prevent infection, accident, and injury;

3. Assessing the nursing care needs of the patient, assisting in preparing the interdisciplinary care plan based upon the assessment, providing nursing care services, as specified in the interdisciplinary care plan, reassessing the patient's response to services provided, and revising the interdisciplinary care plan.

i. Each of these activities shall be documented in the patient's medical record; and

ii. A registered professional nurse shall assess each patient to identify the patient's needs and problems and develop the nursing portion of the interdisciplinary care plan;

4. Teaching, supervising, and counseling the patient, the responsible persons, and staff regarding nursing care and the patient's needs.

i. Only a registered professional nurse shall initiate these functions, which may be reinforced by licensed nursing personnel;

5. Participating as part of the interdisciplinary care team in developing, implementing, reviewing, and revising the interdisciplinary care plan;

6. Writing clinical notes and progress notes; and

7. Assisting the patient in activities of daily living based upon the patient's strengths, needs, abilities, and preferences.

8:43H-9.5 Nursing care services related to pharmaceutical services

(a) A rehabilitation hospital's nursing personnel shall ensure that:

1. A prescriber has prescribed, utilizing a written, signed, and dated order, all drugs to be administered to a patient;

2. Drugs are administered in accordance with all Federal and State laws and rules by the following licensed or authorized nursing personnel:

i. Registered professional nurses;

ii. Licensed practical nurses who are trained in drug administration in programs approved by the New Jersey State Board of Nursing;

iii. Nurses with a valid temporary work permit issued by the New Jersey State Board of Nursing; and

iv. Student nurses in a school of nursing approved by the New Jersey State Board of Nursing, under the supervision of a nurse faculty member;

3. Drugs are not pre-poured, and are administered promptly after a dose is prepared by the individual who prepares the dose, except when a unit dose drug distribution system is used;

4. The patient is identified before drug administration, and drugs prescribed for one patient shall not be administered to another patient;

5. After each drug administration, the nurse who administers the drug documents the following in the patient record:

i. Name and strength of the drug;

ii. Date and time of administration;

iii. Dosage administered;

iv. Method of administration; and

v. Signature of the nurse who administered the drug;

6. All drugs are kept in locked storage areas, except intravenous infusion solutions, which shall be stored according to a system of accountability, as specified in the rehabilitation hospital's policies and procedures.

i. Drug storage and preparation areas are kept locked when not in use;

ii. Drugs requiring refrigeration are kept in a separate, locked box in the refrigerator, in a locked refrigerator, or a refrigerator in the locked medication room; and

iii. The refrigerator has a thermometer to indicate the temperature in conformance with the current edition of the United States Pharmacopoeia/National Formulary (USP/NF) available at www.usp.org and www.uspnf.com;

7. Needles and syringes are procured, stored, used, and disposed of in accordance with the laws of the State of New Jersey; and

8. Drugs are stored and verified according to the following:

i. Drugs in Schedules III and IV of the Controlled Substances Act are stored under lock and key;

ii. Drugs in Schedule II of the Controlled Substances Act are stored in a separate, locked, permanently affixed compartment within the locked medication cabinet, medication room, refrigerator, or mobile medication cart.

(1) The key to the separate, locked compartment for Schedule II drugs is not the same as the key that is used to gain access to storage

areas for other drugs (except those drugs in Schedule II in a unit dose drug distribution system shall be kept under double lock and key, but may be stored with other controlled drugs);

iii. The keys for the storage compartments for drugs in Schedules II, III, and IV drugs are kept on a person who meets the criteria listed at (a)2i through iv above; and

iii. At each shift change, a nurse who is going off shift, in consultation with a nurse who is going on shift, each of whom meets the criteria listed at (a)1i through iv above, makes and signs a declining inventory record of all drugs in Schedule II of the Controlled Substances Acts, wherever these drugs are maintained, except for drugs in a unit dose drug distribution system, that contains:

(1) The name of the patient to whom the drug is prescribed;

(2) The prescriber's name;

(3) The name and strength of the drug;

(4) The date received from the pharmacy;

(5) The date of administration, the dosage administered, the method of administration, and the signature of the licensed nurse who administered the drug;

(6) The amount of drug remaining; and

(7) If applicable, the amount of drug destroyed or wasted and the signature of the nurse who witnessed the destruction or waste.

SUBCHAPTER 10. PHARMACEUTICAL SERVICES

8:43H-10.1 Provision of pharmaceutical services

(a) A rehabilitation hospital shall provide pharmaceutical services to patients 24 hours a day, seven days a week, directly in the rehabilitation hospital through a contract with an institutional pharmacy provider.

1. If the rehabilitation hospital has an on-site pharmacy, the following shall be the minimum provided:

i. A dispensing area with a handwashing facility;

ii. An area for compounding; and

iii. Locked storage areas.

(b) If the rehabilitation hospital has an institutional pharmacy, the pharmacy shall be licensed by the New Jersey State Board of Pharmacy and operated in accordance with N.J.A.C. 13:39, New Jersey State Board of Pharmacy Rules, and shall possess a current Drug Enforcement Administration registration and a Controlled Dangerous Substance registration from the Division of Consumer Affairs in accordance with the Controlled Substances Act.

(c) The rehabilitation hospital may use an automated medication system, which is any process that performs operations or activities, other than compounding or administration, relative to the storage, packaging, dispensing, and distribution of medications, which collects, controls, and maintains all transaction information and is compliant with N.J.A.C. 13:39.

8:43H-10.2 Appointment of pharmacist

(a) A rehabilitation hospital shall appoint a pharmacist who is responsible for the direction, provision, and quality of the pharmaceutical service, including:

1. Together with the pharmacy and therapeutics committee, developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the pharmaceutical services;

2. Participating in planning and budgeting for the pharmaceutical services;

3. Coordinating and integrating the pharmaceutical services with other patient care services to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for pharmacy personnel, if any, and assigning duties based upon education, training, competencies, and job descriptions;

5. Participating as part of the interdisciplinary team in developing, implementing, reviewing, and revising the patient treatment plan;

6. Maintaining a means of identifying the signatures of all prescribers authorized to use the pharmaceutical services for prescriptions; and

7. Maintaining records of the transactions of the pharmaceutical services, as required by Federal, State, and local laws, to ensure control and accountability of all drugs, including a system of controls and records for the requisitioning and dispensing of pharmaceutical supplies to all services of the rehabilitation hospital.

8:43H-10.3 Pharmacy and therapeutics committee

(a) A pharmaceutical service shall appoint a multidisciplinary pharmacy and therapeutics committee, which is accountable to the governing authority, and responsible for:

1. Developing policies and procedures, including policies and procedures implementing the requirements at N.J.A.C. 8:43H-10.4 and 10.6, with the documented review and approval by the governing authority, governing:

i. Evaluation, selection, obtaining, dispensing, storing, distributing, administering, using, controlling, accountability, and safety practices of all drugs used in the treatment of patients;

2. Developing, and at least annually reviewing and approving, a current formulary, which includes drugs for treating specific illnesses and substitutions of chemically or therapeutically equivalent drugs for trade-name prescription drugs;

3. Approving the minimum pharmaceutical reference materials to be retained at each nursing unit, kept in the pharmacy, and made available to at least nursing personnel and the medical staff, and methods for communicating product information to at least nursing personnel and the medical staff; and

4. Developing and implementing the rehabilitation hospital’s pharmaceutical quality assurance plan to ensure that the pharmacy complies with the policies and procedures developed pursuant to this section and N.J.A.C. 8:43H-10.4 and 10.6.

8:43H-10.4 Drug administration

(a) A rehabilitation hospital’s policies and procedures shall address patient’s drug administration, as follows:

1. Policies and procedures for the implementation of a unit dose drug distribution system.

i. The rehabilitation hospital shall have a unit dose drug distribution system. At least one exchange of patient medications shall occur every three days. The number of doses for each patient shall be sufficient for a maximum of 72 hours. No more than a 72-hour supply of doses shall be delivered to or available in the patient care area at any time;

ii. Cautionary instructions and additional information, such as special times of administration regarding dispensed medications, shall be transmitted to the personnel responsible for the administration of the medications;

iii. If the rehabilitation hospital repackages medications in single-unit packages, the rehabilitation hospital's policies and procedures shall indicate how such packages shall be labeled to identify the lot number or reference code and manufacturer's or distributor's name; and

iv. Policies and procedures shall specify the drugs that will not be obtained from manufacturers or distributors in single-unit packages and will not be repackaged as single units in the rehabilitation hospital;

2. Methods for procuring drugs on a routine basis, in emergencies, and in the event of a disaster;

3. Policies and procedures regarding emergency kits and emergency carts, including the following:

i. Approval of their locations and contents;

ii. Provision for pediatric doses in areas of the rehabilitation hospital where pediatric emergencies may occur;

iii. Determination of the frequency of checking contents, including expiration dates;

iv. Approval of the assignment of responsibility for checking contents; and

v. A requirement that emergency kits are secure but are not kept under lock and key;

4. Policies and procedures, approved by the medical staff of the rehabilitation hospital, to ensure that all drugs are ordered, in writing, that the written order specifies the name of the drug, dose, frequency, and route of administration, and that the order is signed and dated by the prescriber, and that all drugs are administered in accordance with the laws of the State of New Jersey;

5. Policies and procedures for drug administration, including, but not limited to, the establishment of the times for the administration of drugs prescribed;

6. If rehabilitation hospital policy permits policies and procedures regarding self-administration of drugs. Policies and procedures for self-administration shall include, but not be limited to, the following:

i. A requirement that self-administration be permitted only upon written order of the prescriber;

ii. Storage of drugs;

iii. Labeling of drugs;

iv. Methods for documentation in the patient's medical record of self-administered drugs;

v. Training and education of patients in self-administration and the safe use of drugs; and

vi. Establishment of precautions, so that patients do not share their drugs or take the drugs of another patient;

7. Policies and procedures for documenting and reviewing adverse drug reactions and medication errors.

i. Allergies, including allergy to latex, shall be documented in the patient's open medical record and on its outside front cover, as well as in the patient's pharmacy profile;

8. Policies and procedures for ensuring the immediate delivery of stat *(statim)* doses;

9. If rehabilitation hospital policy permit, policies and procedures for the use of floor stock drugs.

i. A rehabilitation hospital shall maintain a list of floor stock drugs that identifies the amounts in which, and the locations at which, they are stored throughout the rehabilitation hospital;

10. Policies and procedures for discontinuing drug orders, including, but not limited to, the following:

i. The length of time drug orders may be in effect, for drugs not specifically limited as to the duration of use or number of doses when ordered, including intravenous infusion solutions; and

ii. Notification of the prescriber by specified personnel and within a specified period before the expiration of a drug order to ensure that the drug is discontinued if no specific renewal is ordered;

11. Policies and procedures for the use of intravenous infusion solutions, which shall include:

i. An intravenous infusion admixture service operated by the pharmaceutical service;

ii. If the preparation, sterilization, and labeling of parenteral medications and solutions are performed in the exempt areas within the rehabilitation hospital, as specified by rehabilitation hospital policy, but not under the direct supervision of a pharmacist, the pharmacist shall be responsible for providing written guidelines and for approving the procedures; and

iii. Policies and procedures for the use of intravenous infusion solutions, which shall include, but not be limited to, the following:

(1) Safety measures for the preparation, sterilization, and admixture of intravenous infusion solutions. These shall be prepared under a laminar air flow hood, except in patient care areas specified by rehabilitation hospital policy;

(2) Quality control procedures for laminar airflow hoods, including cleaning of the equipment used on each shift, microbiological monitoring as required by the infection prevention and control policies and procedures of the rehabilitation hospital, and documented checks at least every 12 months for operational efficiency; and

(3) The labeling of intravenous infusion solutions, such that a supplementary label is affixed to the container of any intravenous infusion solution to which drugs are added, that shall include: the patient's first and last name and room number; the name of the solution; the name and amount of the drug(s) added; the date and time of the addition; the date, time, and rate of administration; the name or initials of the pharmacy personnel who prepared the admixture; the name, initials, or identifying code of the pharmacist who prepared or supervised the preparation of the admixture; supplemental instructions, including storage requirements; and the expiration date of the solution;

12. Policies and procedures for the storage of intravenous infusion solutions, which shall be stored according to a system of accountability specified in the rehabilitation hospital's policies and procedures;

13. If rehabilitation hospital policy permits policies and procedures for drug research and the use of investigational drugs, in accordance with Federal and State laws, rules, and regulations;

14. Policies and procedures regarding the purchase, storage, safeguarding, accountability, use, and disposition of drugs, in accordance with New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and the Controlled Substances Act;

15. Policies and procedures for the procurement, storage, use, and disposition of needles and syringes in accordance with the laws of the State of New Jersey.

i. There shall be a system of accountability for the purchase, storage, and distribution of needles and syringes; and

ii. There shall be a system of accountability for the disposal of used needles and syringes, which shall not necessitate the counting of individual needles and syringes after they are placed in the container for disposal;

16. Policies and procedures regarding the control of drugs subject to the Controlled Substances Act, in compliance with the New Jersey State Board of Pharmacy Rules, N.J.A.C. 13:39, and all other Federal and State laws, rules, and regulations concerning procurement, storage, dispensing, administration, and disposition. Such policies and procedures shall include, but not be limited to, the following:

i. Provision for a verifiable record system for controlled drugs;

ii. Policies and procedures to be followed if the inventories of controlled drugs cannot be verified, or drugs are lost, contaminated, unintentionally wasted, or destroyed. A report of any such incident shall be written and signed by the persons involved and any witnesses present; and

iii. In all areas of the rehabilitation hospital where drugs are dispensed, administered, or stored, procedures for the intentional wasting of controlled drugs, including the disposition of partial doses, and for documentation which includes the signature of a second person who shall witness the disposition;

17. Policies and procedures for the maintenance of records of prescribers' Drug Enforcement Administration numbers for New Jersey;

18. Specification of the information on drugs, their indications, contraindications, actions, reactions, interactions, cautions, precautions, toxicity, and dosage, to be provided in the pharmacy and each nursing unit.

i. Current antidote information and the telephone number of the regional poison control center shall also be provided in the pharmacy and each nursing unit;

19. A list of abbreviations, metric apothecary conversion charts, and chemical symbols, approved by the medical staff, to be kept in each nursing unit; and

20. Policies and procedures concerning the activities of medical and pharmaceutical sales representatives in the rehabilitation hospital.

i. Drug samples shall not be accepted, placed, or maintained in stock, distributed, or used in the rehabilitation hospital.

8:43H-10.5 Inspection of premises

The pharmacy service shall inspect, at least once every two months, all patient care areas in the hospital, and at least once every three months, all other areas of the hospital where drugs intended for administration to patients are dispensed, administered, or stored. The pharmacy service shall maintain a record of the inspections. Identified problems shall be addressed.

8:43H-10.6 Storage of drugs

(a) A rehabilitation hospital shall store and control all drugs in accordance with the New Jersey Board of Pharmacy rules at N.J.A.C. 13:39-9.23.

(b) A rehabilitation hospital pharmacy shall maintain drugs under proper conditions, as indicated and in accordance with the New Jersey Pharmacy Practice Act at N.J.S.A. 45:14-40, and the rules promulgated pursuant thereto at N.J.A.C. 13:39-11.24.

SUBCHAPTER 11. REQUIRED THERAPY: ADMISSION FOR INTENSIVE REHABILITATION SERVICES

8:43H-11.1 Provision of physical therapy, occupational therapy, speech-language pathology, or orthotics/prosthetics

(a) A rehabilitation hospital shall not admit a patient unless the patient requires the active and ongoing therapeutic intervention of multiple therapy disciplines consisting of at least three hours of therapy, five days a week, of physical therapy, occupational therapy, speech language pathology, or prosthetics/orthotics one of which must be physical or occupational therapy.

1. In certain cases, intensive rehabilitation therapy programs may consist of at least 15 hours of intensive rehabilitation therapy within a seven consecutive calendar day period beginning on the day of admission.

(b) Patient medical record must document a reasonable expectation that, at the time of admission to the rehabilitation hospital, the patient required the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics).

(c) The required therapy treatments shall begin within 36 hours from midnight of the day of admission to the rehabilitation hospital.

(d) Therapy provided shall include any one or any combination therapy as determined by the interdisciplinary team in collaboration with the patient and/or responsible persons.

(e) The rehabilitation hospital shall provide to each pediatric patient, the appropriate combination of rehabilitation therapy services, as determined by the interdisciplinary team in collaboration with the patient and/or responsible persons.

8:43H-11.2 Appointment of a physical therapist, occupational therapist, orthotist/prosthetist, and speech-language pathologist

(a) A rehabilitation hospital shall be responsible for, but not limited to, the quality and competency of occupational therapist(s), physical therapist(s), speech-language pathologist(s), and orthotist/prosthetist(s) practicing at the rehabilitation hospital. A physical therapist, occupational therapist, orthotist/prosthetist, and speech-language pathologist is responsible for, as applicable:

1. Developing and maintaining written objectives, policies, a procedure manual, an organizational plan, and a quality improvement program for the occupational therapy, physical therapy, speech-language therapy, and orthotics/prosthetics, respectively.

2. Planning and budgeting for the occupational therapy, physical therapy, speech-language therapy, and orthotics/prosthetics, respectively;

3. Ensuring that services are provided, as specified in the occupational therapy, physical therapy, speech-language therapy, and orthotics/prosthetics care plan, respectively, and are coordinated with other patient care services to provide a continuum of care for the patient;

4. Developing and maintaining written job descriptions for occupational therapy, physical therapy, speech-language therapy, and orthotics/prosthetics personnel,

respectively, and assigning duties based upon education, training, competencies, and job descriptions; and

5. Ensuring participation in staff education activities and providing consultation to rehabilitation hospital personnel.

(b) An occupational therapist, physical therapist, speech-language pathologist, and orthotist/prosthetist may be employed through contractual agreements that comply with N.J.A.C. 8:43H-3.5.

8:43H-11.3 Patient care by physical therapy, occupational therapy, speech-language pathology, and orthotics/prosthetics

(a) In accordance with the State of New Jersey Physical Therapy Licensing Act of 1983, N.J.S.A. 45:9-37.11 et seq., for physical therapy personnel, the Speech-Language Pathology Practice Act, N.J.S.A. 45:3B-1 et seq., for speech-language pathology, the Occupational Therapy Licensing Act, N.J.S.A. 45:9-37.51 et seq., for the occupational therapist(s), the Orthotist and Prosthetist Licensing Act, N.J.S.A. 45:9-12B.1 et seq., for each occupational therapist, physical therapist, speech-language pathologist, and orthotist/prosthetist shall be responsible for providing patient care, including, but not limited to, the following:

1. Assessing the occupational therapy, physical therapy, speech-language therapy, and orthotics/prosthetics, respectively, of the patient, preparing the interdisciplinary care plan based on the assessment, providing services as specified in the occupational therapy, physical therapy, speech-language therapy, and

orthotics/prosthetics care plan, respectively, reassessing the patient's response to services, and revising the care plan.

i. Each of these activities shall be documented in the patient's medical record;

2. Participating as part of the interdisciplinary team in developing, implementing, reviewing, and revising the interdisciplinary care plan;

3. Writing clinical notes and progress notes; and

4. Assisting the patient in activities of daily living based upon the patient's strengths, needs, abilities, and preferences.

8:43H-11.4 Provisions for consultant services

(a) A rehabilitation hospital shall provide additional services required by a patient and not available inside the rehabilitation hospital "as needed" on an outpatient basis.

1. Services shall be written in the patient's interdisciplinary or multidisciplinary care plan and be ordered by the rehabilitation physician.

2. Transportation shall be arranged through the rehabilitation hospital.

8:43H-11.5 Physical therapy, occupational therapy, speech-language pathology, and orthotics/prosthetics

(a) A rehabilitation hospital shall provide adequate space for:

1. Documentation and administration;

2. Patient waiting areas, if needed;

3. Treatment, exercise, and activity areas, which shall have provisions for a sink and lavatory;

4. Privacy, as needed;

5. Storage for clean linen, supplies, and equipment;

6. Facilities for collection of soiled linen and other materials;

7. Patient toilet rooms; and

8. Activities for daily living, including a bedroom, bathroom, and kitchen with accessible stove.

(b) Space may be planned and arranged for shared use if the functional program reflects this sharing concept.

SUBCHAPTER 12. COUNSELING SERVICES

8:43H-12.1 Provision of counseling services

A rehabilitation hospital shall provide counseling services through appropriately licensed social workers and/or psychologists.

8:43H-12.2 Appointment of social worker or psychologist

(a) A rehabilitation hospital shall appoint a social worker or a psychologist for the purpose of providing counseling services.

(b) The rehabilitation hospital shall be responsible for, but not limited to, the quality and competency of the social work services or psychological services, respectively, including:

1. Developing and implementing written objectives, policies, a procedure manual, an organizational plan, and participating in the rehabilitation hospital's quality improvement program for the social work services or psychology services, respectively;

2. Planning and budgeting for the social work services or psychology services, respectively;

3. Ensuring that services are provided, as specified, in the social work care plan and psychology care plan, respectively, and are coordinated with other patient care services to provide a continuum of care for the patient;

4. Developing and maintaining written job descriptions for social work service personnel or psychology service personnel, respectively, and assigning duties based upon education, training, competencies, and job descriptions; and

5. Ensuring participation in staff education activities and providing consultation to rehabilitation hospital personnel.

8:43H-12.3 Responsibilities of social worker and psychology staff

(a) In accordance with written job descriptions, each social worker and psychology staff member shall be responsible for providing patient care within their scope of practice, including, but not limited to, the following:

1. When indicated, assessing the social work needs or psychological needs, respectively, of the patient, preparing the interdisciplinary care plan based on the assessment, providing services as specified in the interdisciplinary care plan, reassessing the patient's response to services, and revising the interdisciplinary care plan. Each of these activities shall be documented in the patient's medical record;

2. Participating as part of the interdisciplinary team in developing, implementing, reviewing, and revising the interdisciplinary care plan; and

3. Writing clinical notes and progress notes.

8:43H-12.4 Social work and/or psychology services space

A rehabilitation hospital shall provide adequate space for private interviewing and counseling, a waiting area, testing, evaluation, record storage space, administration, and documentation.

SUBCHAPTER 13. EMERGENCY PROCEDURES

8:43H-13.1 Emergency plans and procedures

(a) The rehabilitation hospital shall have a written emergency plan, which shall include procedures to be followed in case of medical emergencies, equipment breakdown, fire, or other disasters.

(b) Procedures for emergencies shall specify persons to be notified, locations of emergency equipment and alarm signals, evacuation routes, procedures for evacuating patients, frequency of fire drills, and tasks and responsibilities assigned to all personnel.

(c) The emergency plans and all emergency procedures shall be conspicuously posted at wheelchair height throughout the facility. Personnel shall be trained in the location and use of emergency equipment in the facility.

(d) Medicare and Medicaid participating rehabilitation hospitals shall comply with the emergency preparedness requirements at 42 CFR 482.15.

8:43H-13.2 Drills and tests

(a) Simulated drills of emergency plans shall be conducted on each shift at least four times a year (a total of 12 drills) and documented, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The four drills on each shift shall include at least one drill for emergencies due to fire. The facility shall conduct at least one drill per year for emergencies due to another type of disaster, such as storm, flood, other natural disasters, bomb threat, or nuclear accident.

(b) The rehabilitation hospital shall test the emergency alarm at random by at least one manual pull alarm three times per quarter and maintain documentation of test dates, location of each manual pull alarm tested, persons testing the alarm, and its condition.

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

SUBCHAPTER 14. DISCHARGE PLANNING SERVICES

8:43H-14.1 Discharge plan

(a) A rehabilitation hospital plan shall provide discharge planning services to patients, as follows:

1. Each patient shall have a discharge plan;

2. Discharge planning shall be initiated at an early stage of the patient’s hospitalization;

3. Plans for discharge shall be reviewed and revised;

4. The patient and, if indicated, the responsible person shall participate in developing and implementing the patient discharge plan. Participation shall be documented in the patient medical record; and

5. The discharge plan shall include instructions given to the patient and/or the patient's responsible person for care following discharge.

8:43H-14.2 Discharge planning policies and procedures

(a) A rehabilitation hospital shall establish and implement written policies and procedures for discharge planning services, which shall describe:

1. The functions of the person or persons responsible for planning, providing, and/or coordinating discharge planning services;

2. The time for completing each patient's discharge plan;

3. The time that may elapse before a reevaluation of each patient's discharge plan is made;

4. Use of the interdisciplinary team in discharge planning;

5. Criteria for patient discharge; and

6. Methods of patient and responsible persons involvement in developing and implementing the discharge plan.

SUBCHAPTER 15. QUALITY ASSURANCE PROGRAM

8:43H-15.1 Quality improvement plan

(a) A rehabilitation hospital shall establish and implement a written plan for a quality assurance program for patient care.

(b) The plan shall specify a timetable and the person(s) responsible for the quality assurance program and shall provide for ongoing monitoring of staff, clinical competencies, and patient care services.

8:43H-15.2 Quality improvement activities

(a) A rehabilitation hospital's quality improvement activities shall include, but not be limited to, the following:

1. At least an annual review of staff and a three-year review of physician qualifications, credentials, and clinical competence;

2. At least annual review of staff orientation and staff education;

3. Evaluation of patients' needs, expectations, and satisfaction; results of infection control activities; safety of the care environment and utilization management; and risk management findings and actions taken;

4. Evaluation by patients and their responsible person of care and services provided by the rehabilitation hospital;

5. Audit of patient medical records (including those of both active and discharged patients) on an ongoing basis to determine if the care provided conforms to criteria established by each patient care service for the maintenance of the quality of care; and

6. Establishment of a patient care outcome assessment system using industry-accepted indicators for the evaluation of the rehabilitation care provided by each service, which includes criteria to be used for the determination of achievement of patient rehabilitation goals.

8:43H-15.3 Measures for corrections and improvements

(a) The rehabilitation hospital staff responsible for the quality assurance program shall submit the results of the quality assurance program to the governing authority at least annually and shall include, at a minimum, deficiencies found and recommendations for corrections or improvements.

1. Deficiencies that jeopardize patient safety shall be reported to the governing authority immediately.

(b) The chief executive or administrator accountable for rehabilitation services shall, with the approval of the governing authority, implement measures to ensure that corrections or improvements are made pursuant to the recommendations of the quality assurance report provided at (a) above.

SUBCHAPTER 16. PHYSICAL PLANT

8:43H-16.1 Standards for construction, alteration, or renovation of rehabilitation facilities

(a) The standards for construction of rehabilitation facilities in new buildings, additions, alterations, and renovations to existing buildings shall be in accordance with:

1. The New Jersey Uniform Construction Code, N.J.A.C. 5:23, Use Group I-2;

2. Standards imposed by the United States Department of Health and Human Services;

3. The Americans with Disabilities Act, 42 U.S.C. §§ 12101 et seq.;

4. Applicable standards of the New Jersey Departments of Health and Community Affairs; and

5. The FGI Guidelines.

SUBCHAPTER 17. FUNCTIONAL REQUIREMENT

8:43H-17.1 Provision for persons with physical disabilities

A rehabilitation hospital shall make its facilities available and accessible to physically disabled persons, pursuant to the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101 et seq., and the New Jersey Uniform Construction Code, N.J.A.C. 5:23-7, Barrier Free Subcode.

8:43H-17.2 Functional service areas

(a) A rehabilitation hospital shall have the following service areas on-site or available, if applicable:

1. Administration services;
2. Dietary services with nutritional counseling;
3. Educational services;
4. Employee facilities;
5. Engineering service and equipment areas;
6. Housekeeping services;
7. Laboratory services;
8. Linen services;
9. Medical evaluation services;
10. Nursing services;
11. Occupational therapy;
12. Orthotic and prosthetic services;

13. Pharmacy services;

14. Physical therapy services;

15. Psychology service with sexual counseling services;

16. Radiology services;

17. Recreation therapy services;

18. Social work services;

19. Speech-language pathology;

20. Sterilization services; and

21. Vocational services.

(b) A rehabilitation hospital shall comply with the requirements for details and finishes set forth at N.J.A.C. 8:43H-17.16 and 17.17.

8:43H-17.3 Medical evaluation services

(a) A rehabilitation hospital's medical evaluation service shall include the following:

1. Offices for personnel;

2. At a minimum, one examination room, which shall have a minimum floor area of 140 square feet, excluding such spaces as the vestibule, toilet, closet, and work counter (whether fixed or movable).

i. The minimum room dimension shall be 10 feet.

ii. The room shall contain a lavatory or sink equipped for handwashing, a work counter, storage facilities and a desk, counter, or shelf space for writing; and

3. Medical evaluation services may take place in the patient's room.

8:43H-17.4 Patient dining, recreation therapy, and community spaces

(a) A rehabilitation hospital shall provide patient dining, separate from the patient's room.

1. Patient dining and community spaces may be in separate or adjoining spaces.

(b) For inpatients and residents, a rehabilitation hospital shall provide a total of 30 square feet per bed of community space for the first 100 beds and 27 square feet per bed of community space for all beds in excess of 100.

(c) A rehabilitation hospital shall provide an indoor and an outdoor recreation area.

(d) For outpatients and/or day hospitalization, a rehabilitation hospital shall provide a total of 20 square feet of community space per person if dining is part of the day care program. If dining is not part of the program, at least 10 square feet per person for recreation and community space spaces shall be provided.

(e) A rehabilitation hospital shall provide storage spaces for recreational equipment and supplies.

8:43H-17.5 Dietary services and nutritional counseling

(a) A rehabilitation hospital's construction, equipment, and installation of food service facilities shall meet the requirements of the facilities dietary services program. Services may consist of an onsite conventional food preparation system, a convenience food service system, or an appropriate combination thereof. The following facilities shall be provided, as required, to implement the food service selected:

1. Storage facilities for four days' food supply, including cold storage items;

2. Food preparation facilities, as follows:

i. Conventional food preparation systems with space and equipment for preparing, cooking, and baking;

ii. Convenience food service systems; such as frozen prepared meals, bulk packaged entrees, individually packaged portions, and contractual commissary services with space and equipment for thawing, portioning, cooking, and/or baking;

3. Handwashing facilities located in the food preparation area;

4. Patient meal service facilities for tray assembly and distribution;

5. Dining space for staff and visitors;

6. Commercial dishwashing and tableware washing equipment shall be provided and located in a room or an alcove separate from food preparation and serving areas. Space shall also be provided for receiving, scraping, sorting, and stacking soiled tableware and a separate area for transferring clean tableware to the using areas. A lavatory shall be conveniently available for patients using the food service area;

7. Pot washing facilities;

8. Storage areas or cans, carts, and mobile tray conveyors;

9. Any waste storage facility shall be in a separate room easily accessible to the outside for direct waste pickup or disposal. A janitor's closet shall be located within the food and nutrition services department and shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies;

10. Office(s) or desk space(s) for dietitian(s) or the dietary service manager;

11. Toilets for dietary staff with handwashing facilities, which shall be immediately available; and

12. Self-dispensing icemaking facilities, which may be in an area or room separate from the food preparation area but shall be easily cleanable and convenient to dietary facilities.

(b) Nutritional counseling shall be provided in a location that ensures a patient's privacy.

8:43H-17.6 Administration services

(a) A rehabilitation hospital shall provide a grade-level entrance, sheltered from the weather and able to accommodate wheelchairs, which conforms to the requirements at N.J.A.C. 5:23-7.

(b) A rehabilitation hospital shall provide a lobby, which shall include:

1. Wheelchair storage space(s);

2. A reception and information counter or desk;

3. Waiting space(s);

4. Public toilet facilities;

5. Drinking fountain(s); and

6. Private space with telephone access.

(c) A rehabilitation hospital shall provide:

1. General or individual office(s) for business transactions, records, and administrative and professional staff;

2. Multipurpose room(s) for conferences, meetings, health education, and library services;

3. Storage for employees' personal effects; and

4. Separate space for office supplies, sterile supplies, pharmaceutical supplies, splints and other orthotic supplies, and housekeeping supplies and equipment.

8:43H-17.7 Patient rooms; nursing units

(a) Each newly licensed rehabilitation hospital patient room shall be single-bedded.

(b) For any existing licensed adult rehabilitation hospital that changes the footprint of the patient room(s), the patient rooms for which the footprint is changed shall be single-bedded.

(c) In existing licensed facilities, at least two single bedrooms with a private toilet room shall be provided in each nursing unit. Each patient area, at a minimum, shall have:

1. An area exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules of 140 square feet in single-bed rooms and 125 square feet per bed in rooms with more than one bed;

2. Each bedroom shall have a space for a wheelchair to make a 180-degree turn, which is a clear space of 60 inches in diameter;

3. Each one-bedroom shall have a minimum clear floor space of 36 inches from each side of the bed and 36 inches between the foot of the bed and the wall.

4. Each two-bedroom shall have a minimum clear floor space of 48 inches between the foot of the bed and the wall, 36 inches between the side of the bed and the wall, and 36 inches between beds;

5. Each patient room shall have a window;

6. A nurses' calling system shall be provided, as follows:

i. Each patient room shall be served by at least one calling station for two-way voice communications;

ii. Each bed shall be provided with a call button;

iii. Two call buttons serving adjacent beds may be served by one calling station;

iv. Calls shall activate a visible signal in the corridor at the patient's door; and

v. A nurse's call emergency system shall be provided at each inpatient toilet, bath, and shower room;

7. In new construction, handwashing stations shall be provided in each patient room. In renovations and modernizations, the lavatory may be omitted from the bedroom when a lavatory is provided and designed to serve one single-bedded room, or one two-bedded room and an alcohol-based hand sanitizer shall be installed in the room;

8. Each patient shall have access to a toilet room without having to enter the general corridor area. One toilet room shall serve no more than four beds and no more than two patient rooms;

9. Each patient shall have a wardrobe, closet, or locker with minimum clear dimensions of one foot, 10 inches by one foot, eight inches, suitable for hanging full-length garments.

i. An adjustable clothes rod and adjustable shelf shall be provided; and

10. Visual privacy shall be provided for each patient.

i. In rooms with more than one bed, cubicle curtains shall be provided between beds no more than 12 inches from the floor.

(d) Nursing unit service areas shall be as follows:

1. The following service areas shall be in or readily available to each nursing unit:

i. An administrative nurse station center or nurses' station;

ii. A nurses' workstation;

iii. Storage for administrative supplies;

iv. Handwashing facilities located near the nurses' station and the drug distribution station. One lavatory may serve both areas;

v. Charting facilities for staff;

vi. A lounge and toilet room(s) for staff;

vii. Individual closets or compartments for safekeeping the personal effects of nursing personnel, located convenient to the duty station or in a central location;

viii. A clean workroom or clean holding room;

ix. A soiled workroom or soiled holding room;

x. A drug distribution station shall be provided for the convenient and prompt 24-hour distribution of medicine to patients.

(1) Distribution may be from a medicine preparation room, a self-contained medicine dispensing unit, or through another Department-approved system.

(2) If used, a medicine preparation room shall be under the nursing staff's visual control and contain a work counter, refrigerator, and locked storage for biological products and drugs.

(3) A medicine dispensing unit may be located at a nurses' station, in the clean workroom, or in an alcove or other space under the visual observation of nursing or pharmacy staff;

xi. Clean linen storage with a separate closet or an area within the clean workroom provided for this purpose. If a closed-cart system is used, storage may be in an alcove;

xii. A nourishment station, which shall contain a sink for handwashing, equipment for serving nourishment between scheduled meals, a refrigerator, storage cabinets, and icemaker-dispenser units;

xiii. An equipment storage room for equipment such as IV stands, inhalators, air mattresses, and walkers; and

xiv. Parking for stretchers and wheelchairs which shall be located out of the path of normal traffic.

2. Although identifiable spaces are required for each indicated function, consideration will be given to alternative designs that accommodate some functions without designating specific areas or rooms.

3. Each service area may be arranged and located to serve more than one nursing unit, but at least one such service area shall be provided on each nursing floor.

(e) A rehabilitation hospital shall provide bathtubs or showers at a ratio of one bathing facility for every eight beds not otherwise served by bathing facilities within patient

rooms. Each tub or shower shall be in an individual room or privacy enclosure that provides space for the private use of bathing fixtures, for drying and dressing, and a wheelchair and an assistant. Showers in central bathing facilities shall be at least four feet square, curb-free, and designed for use by a wheelchair patient.

(f) A rehabilitation hospital shall provide patient toilet facilities, as follows:

1. The minimum dimensions of a room containing only a toilet shall be three feet by six feet of clear space; additional space shall be provided if a lavatory is located within the same room. Toilets shall be usable by wheelchair patients;

2. At least one room, other than a patient room, shall be provided for toilet transfer training. A minimum clearance of three feet shall be provided at the front and on each side of the toilet. This room shall also contain a lavatory;

3. A toilet room that does not require travel through the general corridor shall be accessible to each central bathing area;

4. Doors to toilet rooms shall have a minimum width of two feet, 10 inches to admit a wheelchair. The doors shall permit access from the outside in case of an emergency and swing outward; and

5. A handwashing facility shall be provided for each water closet in each multi-fixture toilet room.

8:43H-17.8 Radiology services

(a) A rehabilitation hospital radiology service shall contain the following:

1. Radiographic room(s);

2. Image processing facilities;

3. Viewing and administration area(s);

4. Image storage facilities;

5 A toilet room with a handwashing facility;

6. A waiting area; and

7. A holding area for stretcher patients.

(b) A portable x-ray with Image processing facilities may be used if required by the program.

8:43H-17.9 Laboratory services

(a) A rehabilitation hospital shall provide laboratory services within the rehabilitation hospital or through contract arrangement with a hospital or laboratory service for hematology, clinical chemistry, urinalysis, cytology, pathology, and bacteriology.

1. If laboratory services are provided on-site; the following shall be the minimum provided:

i. Laboratory work counter(s) with a sink, and gas and electric service;

ii. Handwashing facilities;

iii. Storage cabinet(s) or closet(s);

iv. Specimen collection facilities. Urine collection rooms shall be equipped with a water closet and lavatory. Blood collection facilities shall have space for a chair and work counter; and

v. A refrigerator.

8:43H-17.10 Sterilization of medical equipment

A rehabilitation hospital shall provide a system for sterilizing equipment and supplies, when necessary, for the services it provides.

8:43H-17.11 Linen services

(a) If linen is to be processed on the site, the rehabilitation hospital shall provide the following:

1. A laundry processing room with commercial equipment that can process seven days' laundry within a regularly scheduled workweek, with handwashing facilities;

2. A soiled linen receiving, holding, and sorting room with handwashing and cart-washing facilities;

3. Storage for laundry supplies;

4. A clean linen storage, issuing, and holding room or area; and

5. A janitor's closet, containing a floor receptor or service sink and storage space for housekeeping equipment and supplies.

(b) If linen is processed off of the rehabilitation hospital site, the rehabilitation hospital shall provide the following:

1. A soiled linen holding room; and

2. A clean linen receiving, holding, inspection, and storage room(s).

8:43H-17.12 Housekeeping services

(a) A rehabilitation hospital shall provide a janitor's closet for each nursing unit.

1. A janitor's closet may serve two nursing units if they are on the same floor and adjacent to each other.

(b) A rehabilitation hospital shall provide janitor closets throughout the rehabilitation hospital, as required, to maintain a clean and sanitary environment.

8:43H-17.13 Employee facilities

A rehabilitation hospital shall provide lockers, lounges, and toilets for employees and volunteers that are separate from those available to the public.

8:43H-17.14 Engineering service and equipment areas

(a) A rehabilitation hospital shall provide equipment room(s) for boilers, mechanical equipment, and electrical equipment in accordance with N.J.A.C. 5:23.

(b) A rehabilitation hospital shall provide storage rooms for building maintenance supplies and yard equipment.

(c) A rehabilitation hospital shall provide space and facilities for the sanitary storage and disposal of waste shall conform to the requirements prescribed by the New Jersey Department of Environmental Protection in accordance with N.J.A.C. 7:26.

8:43H-17.15 Pediatric educational services

(a) A rehabilitation hospital shall provide space for pediatric educational services.

(b) In a pediatric unit, there shall be classroom(s) or learning spaces available for pediatric patients, as required by the New Jersey Department of Education, N.J.A.C. 6A:16-10.1.

8:43H-17.16 Facility details

(a) A rehabilitation hospital shall ensure that its facility complies with the following:

1. Compartmentation, exits, automatic extinguishing systems, and other details relating to fire prevention and fire protection in inpatient rehabilitation facilities shall comply with requirements listed in the New Jersey Uniform Construction Code, N.J.A.C. 5:23;

2. Items, such as drinking fountains, vending machines, and portable equipment shall not restrict corridor traffic or reduce the corridor width below the required minimum;

3. Rooms containing bathtubs, showers, and toilets, which are subject to patient use shall be equipped with doors and hardware that will permit access from the outside in an emergency. When such rooms have only one opening, the doors shall open outward or be otherwise designed to open without pressing against a patient who may have collapsed within the room;

4. The minimum width of all doors to rooms needing access for beds shall be 45 and a half inches. Doors to rooms requiring access for stretchers and doors to patient toilet rooms and other rooms needing access for wheelchairs shall comply with local, State, and Federal requirements;

5. Doors between corridors and rooms or those leading into spaces subject to occupancy, except elevator doors, shall be swing type. Openings to showers, baths, patient toilets, and other small wet areas not subject to fire hazards are exempt from this requirement;

6. Doors, except as provided at (a)3 above, such as small closets not subject to occupancy, shall not swing into corridors in a manner that obstructs traffic flow or reduces the required corridor width;

7. Windows and outer doors that may be frequently left open shall be provided with insect screens;

8. Patient rooms intended for occupancy shall have windows that operate without the use of tools and shall have sills not more than three feet above the floor;

9. Doors, sidelights, borrowed light, and windows glazed to within 18 inches of the floor shall be constructed of safety glass, wired glass, or plastic glazing material that resists breaking or creates no dangerous cutting edges when broken. Similar materials shall be used in wall openings of playrooms and exercise rooms. Safety glass or plastic glazing material shall be used for shower doors and bath enclosures;

10. Linen and refuse chutes shall comply with the New Jersey Uniform Construction Code, N.J.A.C. 5:23, and any applicable New Jersey Department of Environmental Protection requirements;

11. Thresholds and expansion joint covers shall be flush with the floor surface, to facilitate the use of wheelchairs and carts;

12. Grab bars shall be provided at all patient toilets, bathtubs, showers, and sitz baths. The bars shall have one and one-half inch clearance to walls and shall be sufficiently anchored to sustain a concentrated load of 250 pounds. Special consideration shall be given to shower curtain rods, which may be momentarily used for support;

13. Handrails shall be provided on both sides of corridors used by patients. A clear distance of one and one-half inches shall be provided between the handrail and wall, and the top of the rail shall be 32 inches above the floor;

14. Ends of handrails and grab bars shall be constructed to prevent snagging the clothes of patients;

15. The location and arrangement of handwashing facilities shall permit proper use and operation. Care shall be given to clearance required for blade-type operating handles. Lavatories intended for use by disabled patients shall be installed to permit wheelchairs to fit under them;

16. Mirrors shall be arranged for use by wheelchair patients, as well as by patients in a standing position;

17. Provisions for hand drying shall be included at all handwashing facilities;

18. Lavatories and handwashing facilities shall be securely anchored to withstand an applied vertical load of not less than 250 pounds on the front of the fixture;

19. Radiation protection requirements of x-ray and gamma-ray installations shall conform to applicable State and local laws. Provisions shall be made for testing the completed installation before use. All defects shall be corrected before the use of equipment;

20. The minimum ceiling height shall be seven feet, 10 inches, with the following exceptions:

i. Boiler rooms shall have a ceiling clearance not less than two feet, six inches above the main boiler head and connecting piping;

ii. Ceilings of radiographic and other rooms containing ceiling-mounted equipment, including those with ceiling-mounted surgical light fixtures, shall have sufficient height to accommodate the equipment and/or fixtures;

iii. Ceilings in corridors, storage rooms, toilet rooms, and other minor rooms shall not be less than seven feet, eight inches; and

iv. Suspended tracks, rails, and pipes located in the path of normal traffic shall not be less than six feet, eight inches above the floor;

21. Recreation rooms, exercise rooms, and similar spaces where impact noises may be generated shall not be located directly over patient bed areas unless special provisions are made to minimize such noise;

22. Rooms containing heat-producing equipment (such as boiler or heater rooms and laundries) shall be insulated and ventilated to prevent any floor surface above and below from exceeding a temperature of 10 degrees Fahrenheit (six degrees Celsius) above the ambient room temperature; and

23. Noise reduction criteria standards available in the FGI Guidelines shall apply to partition, floor, and ceiling construction in inpatient areas.

8:43H-17.17 Facility finishes

(a) A rehabilitation hospital shall ensure that its facility complies with the following:

1. Cubicle curtains and draperies shall be noncombustible or rendered flame retardant;

2. Floor materials shall be readily cleanable and wear-resistant for the location. Floors in food preparation or assembly areas shall be water-resistant. Joints in tile and similar materials in such areas shall also be resistant to food acids. In all areas frequently subject to wet cleaning methods, floor materials shall not be physically affected by germicidal and cleaning solutions. Floors subject to traffic while wet, such

as shower and bath areas, kitchens, and similar work areas, shall have a non-slip surface;

3. Wall bases in kitchens, soiled workrooms, and other areas that are frequently subject to wet cleaning methods shall be monolithic and covered with the floors, tightly sealed within the wall, and constructed without voids that can harbor insects;

4. Wall finishes shall be washable and, in the proximity of plumbing fixtures, shall be smooth and moisture resistant. Finish, trim, and floor and wall construction in dietary and food preparation areas shall be free from spaces that can harbor pests;

5. Floor and wall areas penetrated by pipes, ducts, and conduits shall be tightly sealed to minimize entry of pests. Joints of structural elements shall be similarly sealed; and

6. Ceilings throughout shall be readily cleanable. All overhead piping and ductwork in the dietary and food preparation area shall be concealed behind a finished ceiling. Finished ceilings may be omitted in mechanical and equipment spaces, shops, general storage areas, and similar spaces, unless required for fire-resistive purposes.

(b) Acoustical ceilings shall be provided for corridors in inpatient areas, nurses' stations, dayrooms, recreational rooms, dining areas, and waiting areas.