

HEALTH

HEALTH FACILITIES EVALUATION AND LICENSING DIVISION

OFFICE OF CERTIFICATE OF NEED AND HEALTHCARE FACILITY LICENSURE

Hospice Licensing Standards

Proposed Amendments: N.J.A.C. 8:42C-1.2, 2.4, 2.5 and 3.2

Proposed New Rules: N.J.A.C. 8:42C-11

Authorized By: _____

Mary E. O'Dowd, M.P.H., Commissioner, Department of Health (with the approval of the Health Care Administration Board).

Authority: N.J.S.A. 26:2H-79 and 81, and 26:2H-12.

Calendar Reference: See Summary below for exemption from calendar requirement.

Proposal Number: PRN 2013- .

Submit electronic comments to <http://www.nj.gov/health/legal/ecomments.shtml>

or written comments by _____, 2013 to:

Joy L. Lindo, Director

Office of Legal and Regulatory Compliance

Office of the Commissioner

New Jersey Department of Health

PO Box 360

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The agency proposal follows:

Summary

On April 24, 1997, P.L. 1997, c. 78, codified at N.J.S.A. 26:2H-79 through 81, was enacted. N.J.S.A. 26:2H-79 established standards for hospice care programs operating in New Jersey, specifying the care and services that must be provided to hospice patients and their families. N.J.S.A. 26:2H-81 required the Department to develop rules for licensure of hospice care programs as necessary to implement N.J.S.A. 26:2H-79 through 81. The rules at N.J.A.C. 8:42C fulfilled this statutory mandate and the Department now proposes to amend N.J.A.C. 8:42C-1.2, 2.4, 2.5 and 3.2 and propose a new subchapter at N.J.A.C. 8:42C-11 to provide regulations for inpatient hospice care providers. The only existing manner by which a freestanding inpatient hospice can obtain licensure is by applying for licensure as a comprehensive personal care home in accordance with N.J.A.C. 8:36. There are currently five inpatient hospices licensed in this manner.

The Department worked with stakeholders to undertake a comprehensive analysis of inpatient hospice services in New Jersey. The proposed amendments to N.J.A.C. 8:42C-1.2, 2.4, 2.5, and 3.2 and the proposed new rules at N.J.A.C. 8:42C-11 are the result of this process.

The Department expects that the rules proposed for amendment and proposed new rules would bring uniformity and consistency to the delivery of inpatient hospice care Statewide. The proposed new rules would permit the Department to ensure the

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quality of services provided by inpatient hospice care programs through effective inspections and appropriate enforcement.

Following is a summary of the proposed amendments and new rules:

The Department proposes to amend existing N.J.A.C. 8:42C-1.2 to add definitions of the terms, “family,” “inpatient hospice care provider,” “inspection,” “unit,” and “unit manager.” These terms appear throughout the proposed new rules at N.J.A.C. 8:42C-11.

The Department proposes to amend N.J.A.C. 8:42C-2.4 to add license application, renewal and biennial inspection fees for inpatient hospice care providers. These fees would be payable in addition to hospice licensure fees.

The Department proposes to amend existing N.J.A.C. 8:42C-2.5 by adding new subsection (o), which would provide that a licensed facility may keep beds that were in space leased to a third-party inpatient hospice care unit operator licensed and inoperative for a maximum of two years.

The Department proposes to amend existing N.J.A.C. 8:42C-3.2 to address transfers of ownership.

The Department proposes a new subchapter at N.J.A.C. 8:42C-11. This subchapter would establish standards for hospice care providers that operate an inpatient hospice unit.

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Proposed new N.J.A.C. 8:42C-11.1 would set forth the requirements for a licensed inpatient hospice care provider. This includes State licensure as a hospice facility and certification from the Centers for Medicare and Medicaid Services.

Proposed new N.J.A.C. 8:42C-11.2 would require the appointment of a unit administrator and the designation of a unit manager who would supervise the unit in the absence of the unit administrator. It further would require unit administrators or unit managers to be available at all times and be in the building in which the unit is located for at least a half-time per week basis. It further would require inpatient hospice care providers to provide 24-hour nursing services and to meet the needs of patients' plans of care. It further would require two staff members to be in the unit at all times, one of whom would have to be a registered professional nurse, who may also be the unit manager or unit administrator, and the other a licensed or certified healthcare worker. It further would require inpatient hospice care providers to have or to cause to have sufficient qualified staff to meet patient needs.

Proposed new N.J.A.C. 8:42C-11.3 would require inpatient hospice care providers to assure or provide duly licensed radiology, laboratory, pathology and other medically related services according to physicians' orders. These services would have to be under the direction of a physician qualified by education, training and experience to assume that function.

Proposed new N.J.A.C. 8:42C-11.4 would provide the physical area requirements of inpatient hospice care units. It would establish requirements for unit

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size, room capacity, occupancy level, usable floor area for each room, clearances around each bed, space requirements for dining, recreation and other common areas, wardrobe or closet requirements, minimum bathroom requirements, handsinks, grab bar and handgrips and a mandatory nurse call system. It further would establish requirements for medication preparation areas, clean utility rooms, soiled utility rooms, staff bathrooms and locker spaces, nourishment stations, soiled linen storage areas, clean linen storage areas, housekeeping closets, location of office spaces, areas for staff lounges and family visitation areas, the atmosphere for kitchen and dining areas, accommodations for patient and family member privacy and for family members to remain with patients. Proposed new (y) would require inpatient hospice care providers to comply with the Guidelines for Design and Construction of Health Care Facilities (2010), as amended and supplemented.

Proposed new N.J.A.C. 8:42C-11.5 would require inpatient hospice care providers to develop and implement systems to investigate, report, evaluate and maintain records of infections among patients and staff. It would require these systems to incorporate the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, pursuant to the Occupational Safety and Health Act of 1970. It further would require these systems to provide procedures for isolating patients with infectious diseases.

Proposed new N.J.A.C. 8:42C-11.6 would require inpatient hospice care providers to employ or otherwise have documented agreements with licensed

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pharmacists to establish and implement written policies and procedures on ordering, storage, administration, disposal and recordkeeping of drugs and biologicals. It further would require the inpatient hospice care provider to establish and implement written policies and procedures to govern the procurement, storage, administration and disposal of all drugs and biologicals according to Federal and State laws and for drug control and accountability. Finally, it would require inpatient hospice care providers to maintain emergency drug kits for the needs of patients.

Proposed new N.J.A.C. 8:42C-11.7 would require inpatient hospice care providers to comply with N.J.A.C. 8:42C-5.1, which generally sets forth patients' rights in the hospice setting.

Proposed new N.J.A.C. 8:42C-11.8 would establish dietary service and nutrition staffing requirements for inpatient hospice care providers. It would require inpatient hospice care providers to provide dietary services directly or through food service providers with documented agreements. It would require dietary services to comply with N.J.A.C. 8:24 Sanitation in Retail Food Establishments and Food and Vending Machines. It further would require units to have a staff member who is trained or experienced in food management or nutrition to be responsible for menu planning and supervising meal preparation. It further would require inpatient hospice care providers to provide therapeutic or special diets, have an approved dietary manual for reference when preparing meals, and have a registered dietician or registered nurse provide dietary counseling to patients who experience unmet nutritional needs.

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Proposed new N.J.A.C. 8:42C-11.9 would require inpatient hospice care providers to provide laundry services to meet patients' needs. It further would require inpatient hospice care providers that contract for laundry services to have documented agreements for the contracted services containing with the details of the provided services.

Proposed new N.J.A.C. 8:42C-11.10 would require inpatient hospice care providers provide housekeeping services to maintain a clean, healthy and sanitary environment. It further would require inpatient hospice care providers that contract for housekeeping services to have documented agreements for the contracted services containing with the details of the provided services.

Proposed new N.J.A.C. 8:42C-11.11 would require inpatient hospice care providers to have and implement policies and procedures addressing whether pets are to be allowed in the unit, and, if they are permitted, establishing mechanisms to assure staff and patient safety and measures to prevent staff and patient discomfort.

Proposed new N.J.A.C. 8:42C-11.12 would require units to have written emergency preparedness plans and would require annual and new staff training and a prescribed number of drills.

Proposed new N.J.A.C. 8:42C-11.13 would require inpatient hospice care providers to meet applicable Federal, State, and local laws, regulations and codes pertaining to health and safety.

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Because the Department has provided a 60-day comment period for this notice of proposal, this notice is excepted from the calendar requirement set forth at N.J.A.C. 1:30-3.3(a)5.

Social Impact

N.J.S.A. 26:2H-79 through 81 direct the Department to develop “standards and procedures” for licensing inpatient hospice care programs to ensure high-quality hospice services to the residents of New Jersey in a coordinated and cost-effective manner. The proposed amendments and new rules would satisfy this directive by establishing appropriate minimum requirements for the provision of inpatient hospice care services in New Jersey that promote the delivery of these services at a high quality level.

As described above in the Summary, the Department currently licenses facilities providing inpatient hospice services as comprehensive personal care homes in accordance with N.J.A.C. 8:36. This process requires prospective licensees, and the Department in processing such applications, to adhere to the process for obtaining a certificate of need. The proposed amendments and new rules would streamline the licensure of inpatient hospice care services by establishing standards specific to inpatient hospice care units that eliminate the need for adherence to the certificate of need process.

The proposed amendments and new rules would have a positive social impact on patients in need of hospice services, their families and caregivers, and inpatient

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hospice care providers. The Department acknowledges the generally positive social impact of the inpatient hospice care movement upon hospice patient quality of life in this State. Inpatient hospice care providers generally strive to provide homelike environments for terminally ill patients. The proposed amendments and new rules, together with the Medicare certification standards, would promote high-quality palliative care for terminally ill patients. The proposed amendments and new rules would facilitate hospice patients' receipt of the diverse services needed during the final stages of their lives in a homelike environment as inpatients, while providing their families and caregivers with an alternative to home-based hospice care and the respite opportunities that would follow therefrom, with the reassurance that, even when they are absent, their terminally ill family members are receiving quality care.

The proposed amendments and new rules would continue to ensure that the needs of patients and their families are met by requiring the employment of qualified staff and well trained volunteers, appropriate record-keeping, and policies and procedure to govern patient care services. The proposed amendments and new rules would help to ensure that patients admitted to inpatient hospice care units to receive palliative care retain dignity and the greatest degree of independence possible during the final stages of their lives.

The proposed amendments and new rules would help inpatient hospice care providers to obtain the best patient outcomes by requiring their adherence to best practices. The establishment of specific staffing standards for inpatient hospice care

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units would help to assure the provision of appropriate staff supervision and patient care. Requiring inpatient hospice care providers to adhere to longstanding patient rights standards would enhance patients' ability to have greater autonomy in decision-making. Requiring inpatient hospice care providers to adhere to infection prevention and control practices would help to minimize the occurrence of medical complications due to the spread of infection, which is particularly relevant in the care of terminally ill patients who are likely to be immunocompromised. Requiring inpatient hospice care providers to adhere to dietary services standards would help to ensure that patients receive appropriate food and nutrition management from qualified staff in compliance with existing sanitation standards.

The proposed amendments and new rules would play an important role in maintaining satisfactory levels of patient care for existing Medicare-certified providers and in monitoring the quality of care provided by new providers. The proposed amendments and new rules will help to ensure the provision of accessible high-quality care to hospice patients and their families and caregivers.

Economic Impact

The Department anticipates that the proposed amendments and new rules will enhance services by providing a set of rules that will not only permit providers to explore additional services options but also improve the quality of services provided.

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Presently, inpatient hospice providers must meet Comprehensive Personal Care Home (CPCH) standards in order to open a freestanding inpatient hospice. As the licensure of a CPCH involves an expedited CN application, the proposed new rules for inpatient hospice providers would save applicants for licensure the cost of the CN application fee as well as the time necessary to review the application.

In addition, these rules will improve the efficiency of payment for inpatient hospice providers. Because the Department currently licenses existing providers of inpatient hospice care as comprehensive personal care homes pursuant to N.J.A.C. 8:36, the Centers for Medicare and Medicaid Services (CMS) treats these providers as assisted living facilities for reimbursement purposes. This has resulted in difficulties for providers in obtaining reimbursement for the special services provided in hospices that are different from those provided in assisted living facilities. The proposed amendments and new rules would have a positive economic impact on inpatient hospice providers seeking CMS reimbursement by establishing a licensing category for inpatient hospice providers that takes into account the differences between inpatient hospice and assisted living facilities.

The Department anticipates that the proposed amendments and new rules will not change the economic impact currently realized by existing inpatient hospice care providers already licensed under certificate of need standards. This is because the proposed amendments and new rules are generally consistent with existing Federal

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Medicare certification standards to which licensees are already subject, as described more fully in the Federal Standards Analysis, below.

New applicants for licensure would incur nonrefundable license application fees, and new and existing licensees applying for renewal of licensure would incur nonrefundable license renewal application fees, of \$1,500, plus \$15.00 per bed, not to exceed the cap established at N.J.S.A. 26:2H-80b. In addition to license application fees, licensees would incur a biennial inspection fee of \$1,500, in accordance with N.J.S.A. 26:2H-12.

The proposed amendments and new rules would allow inpatient hospice care providers to contract for particular required services such as food and laundry services. This may result in cost savings to providers who may find it more economical to have these services provided by contractors rather than by in-house staff.

The proposed amendments and new rules would require the Department to process applications for licensure and licensure renewal, conduct compliance surveys, respond to complaints and develop and maintain appropriate licensure rules. These are services the Department already provides for these types of facilities (as comprehensive personal care facilities) and other licensed healthcare facilities. The Department would absorb the performance of these services for inpatient hospice care providers within its existing staff and infrastructure. Therefore, the Department does not anticipate that the proposed amendments and new rules would change the existing cost the Department incurs to perform these services. The Department has the authority to increase fees, as

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necessary, through rulemaking and within specific limits in accordance with N.J.S.A. 26:2H-12 and 80b.

Federal Standards Analysis

The proposed amendments and new rules at N.J.A.C. 8:42C are generally consistent with the Medicare Certification Standards for Hospice, established pursuant to 42 C.F.R. Part 418, with which inpatient hospice care providers must comply to obtain Medicare certification and eligibility for Medicare reimbursement. However, the proposed amendments and new rules would continue to exceed these Federal certification standards with respect to the required employee health standards, especially for direct patient care workers, patient rights policies and procedures, and infection prevention and control program. The proposed enhanced standards would be consistent with the standards the Department has established as required in other New Jersey licensed healthcare facilities. New Jersey consumers of healthcare facility services have come to expect these enhanced requirements as standard across all New Jersey licensed healthcare facilities. The Department has determined it is likewise appropriate to make these standards applicable to the care provided to hospice patients and their families and caregivers to ensure that consistent level of care and quality.

The cost to comply with implementation of patient rights requirements in licensed healthcare facilities generally is not significant within the context of provision of other healthcare services. Outbreaks of communicable disease among patients and staff can result in death and, at the very least, staff absenteeism. The cost to facilities to comply

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with enhanced employee health standards and to implement infection prevention and control programs is less than the cost to respond to outbreaks and their consequences. The implementation of these requirements to is particularly appropriate in the context of treating hospice patients, who may likely be immunocompromised and/or who may be hospice patients because they have communicable disease diagnoses.

Jobs Impact

The Department does not expect that any jobs will be generated or lost as a result of the proposed amendments and new rules.

Agriculture Industry Impact

The proposed amendments and new rules would not have an impact on the agriculture industry of the State.

Regulatory Flexibility Analysis

The proposed amendments and new rules would impose reporting, recordkeeping and compliance requirements on existing licensed hospice care providers and applicants for licensure as hospice care providers. The majority of these entities may be small businesses, as the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. defines that term. The Summary, above, describes these requirements. These entities would incur costs to comply with the proposed amendments and new rules. The Economic Impact, above, describes these costs.

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As described in the Summary above, the proposed amendments and new rules would require licensed hospice care providers to retain the services of professionals, such as direct care and administrative staff, to comply. The costs to retain these professionals will vary based on factors arising from regional norms for each professional's level of education and training. The professionals that licensees would need to retain are the same as those that existing Medicare certification and reimbursement standards require them to retain, and are necessary for compliance with N.J.S.A. 26:2H-79.

The Department does not propose lesser or differing standards based on business size. The Department has determined that the proposed amendments and new rules would establish the minimum standards necessary to ensure patient and staff health and welfare and to maintain consistent levels of quality hospice care across the State, regardless of whether a large or small hospice care program is providing that care. N.J.A.C. 8:42C authorizes licensees and applicants for licensure to seek waiver of certain licensing requirements provided the waiver application proposes an alternative that ensures patient safety.

Housing Affordability Impact

The proposed amendments and new rules would have an insignificant impact on affordable housing in New Jersey and there is an extreme unlikelihood that they would evoke a change in the average costs associated with housing because the proposed amendments and new rules would establish licensure standards for hospice services.

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Smart Growth Development Impact

The proposed amendments and new rules would have an insignificant impact on smart growth and there is an extreme unlikelihood that they would evoke a change in housing production in Planning areas 1 or 2 or within designated centers under the State Development and Redevelopment Plan in New Jersey because the proposed amendments and new rules would establish licensure standards for hospice services.

Full text of the proposed amendments and new rules follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

8:42C-1.2 Definitions

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

...

“Family” means persons related by blood, marriage, domestic partnership or civil union.

...

“Inpatient hospice care provider” means an entity that is licensed to operate an inpatient hospice care unit in accordance with N.J.A.C. 8:42C-11 and who is a Centers for Medicare and Medicaid Services-certified hospice provider, meeting the requirements for participation at 42 C.F.R. §418.110, as amended and supplemented.

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“Inspection” means a survey, inspection, investigation, or other regulatory oversight activity necessary for the Department to carry out an obligation imposed by applicable State licensing rules and statutes, and/or Federal Medicare and/or Medicaid certification regulations and/or statutes, including any on-site visit to a hospice by Department staff to determine a hospice’s compliance with applicable State licensing rules, statutes, or Federal Medicare and/or Medicaid certification regulations or statutes.

...

“Unit” means an inpatient hospice care unit that is operated by a licensed inpatient hospice care provider in accordance with N.J.A.C. 8:42C-11.

“Unit manager” means a registered professional nurse who is designated to supervise the unit in the absence of the unit administrator.

8:42C-2.4 Licensure application

(a) The applicant shall submit to the Department a nonrefundable fee of \$ 2,000 for the filing of an application for licensure of a hospice and \$ 2,000 for the annual renewal of the license.

1. (No change).

2. An additional nonrefundable fee of \$1,500, plus \$15.00 per bed (for the number of licensed beds) shall be submitted for the filing of an application to add

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an inpatient hospice care unit to a license and for each license renewal of an inpatient hospice care unit.

i. These fees shall not exceed the maximum caps set forth at N.J.S.A.

26:2H-12.

(b) – (i) (No change.)

[(j) Each hospice shall be assessed the following biennial inspection fee of \$1,000. For existing facilities, this fee shall be assessed in the year the facility will be inspected, along with the annual licensure fee for that year. The fee shall be added to the initial licensing fee for new facilities. Failure to pay the inspection fee shall result in non-renewal of the license for existing facilities and the refusal to issue an initial license for new facilities. This fee shall be imposed only every other year even if inspections occur more frequently and only for the inspection required to either issue an initial license or to renew an existing license. It shall not be imposed for any other type of inspection.]

(j) Licensees shall incur and pay the following inspection fees at initial licensure and biennially thereafter upon renewal, in addition to the applicable licensure or renewal fee:

Hospice	\$1,000
Inpatient hospice care unit (each site)	\$1,500.

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(k) Failure to pay applicable inspection fees incurred pursuant to (j) above shall result in non-renewal of the license for existing facilities and the refusal to issue an initial license for new facilities.

1. Licensees shall incur inspection fees no more or less frequently than every other year even if inspections occur more or less frequently than every other year.

8:42C-2.5 Licensure

(a) – (h) (No change.)

(i) [Except as set forth below, the] **The** license is not assignable or transferable, and it shall be immediately void if the hospice ceases to operate, if the hospice ownership changes **except as part of an approved transfer of ownership in accordance with the process at (j) below**, if the hospice is relocated to a different site, or if a part of a hospice ceases to operate.

1. If the hospice or a part thereof ceases to operate, the licensee may request that the Department maintain the license for a period of up to 24 months.

i. The licensee shall make such a request at least [30] **60** days prior to ceasing operations, and such request shall include the rationale for requesting the extension and the [time frame] **length** of the **requested** extension.

ii. The Department shall maintain the license if the circumstances indicate that the licensee will again operate the hospice or part [within the time frame of] **before** the

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requested extension [requested] **elapses**, based on the specific circumstances of the case.

iii. To maintain the license, the licensee shall return a completed renewal application and the appropriate fee.

[2] **(j)** In the case of a transfer of ownership[, new owners] of a hospice, **the prospective owners** shall [make application for licensure with] **submit the following** to the Department[, in accordance with the provisions as set forth in N.J.A.C. 8:42C-2.1 and this subchapter. In addition, the following information shall be submitted] with [the] **a completed license** application:

i. – ii. (No change.)

iii. Where applicable, 100 percent of the ownership of leased buildings and property; [and]

iv. Copies of all legal documents pertinent to the transfer of ownership transaction [which] **that** are signed by both the current licensed owners and the proposed licensed owners;

v. A nonrefundable fee of \$1,500 for the filing of an application for the transfer of ownership of the hospice and, upon Department approval of the transfer of ownership, the license fee required pursuant to N.J.A.C. 8:42C-2.4(a); and

vi. Track record information required pursuant to N.J.A.C. 8:42C-2.4(b).

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[(j)] **(k)** The license, unless suspended or revoked, shall be renewed annually on the original licensure date[, or within 30 days thereafter but dated as of the original licensure date].

1. The hospice shall receive a request for renewal fee 30 days prior to the expiration of the license.

2. A renewal license shall not be issued unless the licensure **renewal** fee is received by the Department.

Recodify existing (k)-(l) as new **(l)-(m)** (No change in text.)

(n) If a licensed facility leases beds to a third-party inpatient hospice care unit operator:

1. The licensed facility is not required to file a transfer of ownership application;

2. The facility may keep the beds licensed and inoperative for a maximum of two years in accordance with N.J.A.C. 8:33-3.2(a);

3. After the two-year period has elapsed, the facility shall return the inoperative beds service; and

4. If the facility fails to return the inoperative beds to service following the expiration of the two-year period , the Department shall remove the beds from the facility's license.

8:42C-3.2 Ownership

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(a) The hospice shall disclose the ownership of the hospice and the property on which it is located to the Department[.] **and shall make**

[1. Proof] **proof** of this ownership [shall be] available in the facility.

[2.] **(b)** (No change in text).

(c) A proposed transfer of ownership shall follow the process at N.J.A.C.

8:42C-2.5(j).

[(b)] **(d)** (No change in text).

SUBCHAPTER 11. INPATIENT HOSPICE CARE UNIT

8:42C-11.1 Scope

(a) This subchapter sets forth the requirements for licensed inpatient hospice care providers to operate units.

(b) Inpatient hospice care providers shall be:

1. Licensed hospice providers in compliance with N.J.A.C. 8:42C, except as that chapter may conflict with this subchapter;

i. In the event of a conflict, the licensed hospice provider shall comply with this subchapter; and

2. Certified by the Centers for Medicare and Medicaid Services as hospice providers;

3. Comply with the requirements of 42 C.F.R. § 418.110, as amended and supplemented.

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8:42C-11.2 Additional staffing requirements for inpatient hospice care units

(a) The governing body shall appoint a unit administrator.

1. The unit administrator shall be available at all times and shall be in the building in which the unit is located in at least a half-time basis per week.

(b) The unit administrator shall designate in writing a registered professional nurse as unit manager to act in the absence of a unit administrator.

1. Either the unit administrator or a unit manager shall be on the unit at all times.

(c) Inpatient hospice care providers shall provide 24-hour nursing services that meet the needs of each patient and are in accordance with each patient's plan of care.

(d) Inpatient hospice care providers shall have the following two staff members in the unit at all times:

1. One registered professional nurse, who may be the unit manager or unit administrator; and

2. One licensed or certified healthcare worker.

(e) The unit administrator shall determine the staffing of the unit based on patient care needs.

1. Each inpatient hospice care provider shall have sufficient qualified staff to meet patient needs.

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8:42C-11.3 Additional services required for inpatient hospice care units

(a) Inpatient hospice care providers shall provide, directly or through documented agreements, duly licensed radiology, laboratory, pathology and other medically related services in accordance with physician orders.

1. Documented agreements shall be consistent with N.J.A.C. 8:42C-3.7.

2. If a provider directly provides these services, the provider shall establish and implement written policies and procedures that govern the implementation of these services.

(b) Radiology, laboratory and pathology services shall be under the direction of a physician qualified by education, training and experience to assume that function.

8:42C-11.4 Patient care area requirements for inpatient hospice care units

(a) The maximum unit size shall be 30 beds.

1. These beds shall be in a contiguous area on the same floor.

(b) Maximum room capacity shall be two patients.

(c) At least 50 percent of the unit rooms shall be single occupancy.

(d) The clear, useable floor area of a single bedroom shall be not less than 100 square feet, exclusive of the bathroom, vestibule and closet or wardrobe unit.

(e) The clear, useable floor area of a shared (semi-private) bedroom shall be not less than 80 square feet per bed, exclusive of the bathroom, vestibule and closet or wardrobe unit.

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(f) Each bedroom shall be designed to have a four-foot clearance at each side and at the foot of each bed to permit the passage of equipment, patients and staff.

(g) The space set aside for dining, recreation and other common uses shall be not less than 35 square feet per licensed bed.

1. Physical therapy and occupational therapy space shall not be included in this total space requirement.

(h) Each patient shall have a wardrobe or closet of not less than six square feet for the storage of personal clothing.

(i) Each patient shall have access to a bathroom without having to enter the corridor area:

1. The bathroom door shall either:

i. Swing outward; or

ii. Be an inward swing door that is compliant with the clearance requirements of the Americans with Disabilities Act of 1990, 42 U.S.C.A §12101 et seq.

(j) Each bathroom shall contain:

1. If the unit is newly constructed or is a result of a rehabilitation project in accordance with N.J.A.C. 5:23-6, the Rehabilitation Subcode of the New Jersey Uniform Construction Code, a toilet and a sink.

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2. If the unit is located in an existing licensed healthcare facility providing residential care, a toilet and:

(i) A sink; or

(ii) Alcohol-based hand rinse, in accordance with Centers for Disease Control and Prevention “Guideline for Hand Hygiene in Health-Care Settings, 2002” MMWR. October 25, 2002, Volume 51, Number RR-16, p. 1-48, as amended and supplemented, in which case the bedroom shall contain a sink.

(k) Each bedroom shall contain:

1. A sink, if the unit is newly constructed or is a result of a rehabilitation project in accordance with N.J.A.C. 5:23-6, the Rehabilitation Subcode of the New Jersey Uniform Construction Code;

2. Alcohol-based hand rinse in accordance with Centers for Disease Control and Prevention “Guideline for Hand Hygiene in Health-Care Settings, 2002” MMWR. October 25, 2002, Volume 51, Number RR-16, p. 1-48, as amended and supplemented, if the unit is located in an existing licensed healthcare facility in which the bathroom contains a sink and the bedroom does not contain a sink;
or

3. A sink, if the unit is located in an existing licensed healthcare facility in which the bathroom does not contain a sink.

(l) There shall be a wheelchair and stretcher-accessible central bathing area for staff to bathe patients who cannot bathe independently.

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(m) In accordance with the International Code Council Inc./American National Standards Institute A117.1-2003, grab bars shall be provided for all toilet and bath facilities used by patients.

(n) Handgrips shall be provided on both sides of all corridors used by patients.

(o) A nurse call system shall be provided.

- 1. Each bed shall be provided with a call device; and**
- 2. A call device shall be provided at each patient toilet, bath and shower room.**

(p) The inpatient hospice care provider shall provide a homelike atmosphere in the unit.

(q) Each unit shall have the following:

1. A medication preparation area, located adjacent to the nurses' station or under visual control of the nursing station, that has:

- i. A work counter;**
- ii. A sink;**
- iii. A medication refrigerator;**
- iv. Eye-level medication storage;**
- v. Cabinet storage; and**
- vi. A double-locked narcotic storage room.**

2. A clean utility room that has:

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- i. A work counter;
 - ii. A handwashing-station with handles or paddles that are at least four inches long; and
 - iii. Wall or under-counter space for storage of clean and sterile supplies.
3. A soiled utility room with the following:
- i. A counter;
 - ii. A handwashing-station with handles or paddles that are at least four inches long;
 - iii. Wall or under-counter space for storage;
 - iv. A flush-rim clinical sink or water closet with a device that is suitable for washing and sanitizing bedpans and other utensils.
4. A staff bathroom and locker space for personal belongings;
5. A nourishment station in an area physically separated from the nurses' station that has:
- i. A work counter;
 - ii. A storage cabinet;
 - iii. Refrigerated storage; and
 - iv. A small stove, hotplate or microwave.
6. A nurses' station that has:
- i. Desk space adequate for writing;
 - ii. Storage space for office supplies; and

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iii. Storage space for patient records.

7. A soiled linen storage area;

8. A clean linen storage area; and

9. A minimum of one housekeeping closet per floor of a unit.

(r) Persons with administrative responsibilities for the unit shall have office space in the same building as the unit.

(s) Staff shall have lounge facilities of not less than 100 square feet in the same building as the unit.

(t) Dedicated private space of not less than 100 square feet shall be provided for patient and family visitation.

(u) A homelike kitchen and dining facilities shall be provided to accommodate patients and their visitors.

(v) All patient rooms shall have flameproof privacy screens or curtains for each patient.

(w) Accommodations shall be provided for family members to remain with a patient throughout the night in the patient's room.

(x) Accommodations shall be provided for family privacy after a patient's death.

(y) Inpatient hospice care providers shall meet the requirements of the 2010 edition of Guidelines for Design and Construction of Health Care Facilities (The Facility Guidelines Institute, with the assistance from the U.S. Department of

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Health and Human Services), incorporated herein by reference, as amended and supplemented, published by the American Society of Healthcare Engineering of the American Hospital Association, 155 North Wacker Drive, Chicago, IL 60606, Pub. No. ISBN 978-0-87258-859-2, available through the Facility Guidelines Institute, website www.fgiguilines.org, or by writing to AHA Services, Inc., PO Box 933283, Atlanta, GA 31193-3283.

8:42C-11.5 Inpatient hospice care unit infection control

(a) The inpatient hospice care provider shall develop and implement a system to investigate, report, evaluate and maintain records of infections among patients and staff.

1. The system developed by the inpatient hospice care provider shall incorporate “Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005,” MMWR. December 30, 2005, volume 54, Number RR-17, p. 1-141, as amended and supplemented, in accordance with 29 U.S.C. 651 et. seq., the Occupational Safety and Health Act (OSH ACT) of 1970; and

2. The system shall include a procedure for isolating patients with infectious diseases.

8:42C-11.6 Pharmaceutical services for inpatient hospice care units

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(a) An inpatient hospice care provider shall employ, or have a documented agreement with, a licensed pharmacist to establish and implement written policies and procedures on ordering, storage, administration, disposal and recordkeeping of drugs and biologicals.

(b) Inpatient hospice care providers shall establish and implement written policies and procedures governing:

- 1. The procurement, storage, administration and disposal of all drugs and biologicals in accordance with Federal and State laws; and**
- 2. Drug control and accountability.**

(c) An inpatient hospice care provider shall maintain an emergency drug kit appropriate to the needs of the patients of the facility that is:

- 1. Assembled in consultation with the licensed pharmacist referenced in (a) above; and**
- 2. Readily available for use by staff in the unit.**

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8:42C-11.7 Inpatient hospice care unit patients' rights

(a) Inpatient hospice care providers shall comply with N.J.A.C. 8:42C-5.1.

8:42C-11.8 Food service for inpatient hospice care units

(a) An inpatient hospice care provider shall provide dietary services either directly or through a documented agreement with a food services provider that details the services provided.

(b) The dietary service shall comply with N.J.A.C. 8:24 Sanitation in Retail Food Establishments and Food and Vending Machines.

(c) Each unit shall have a staff member trained or experienced in food management or nutrition who is responsible for:

- 1. Planning menus; and**
- 2. Supervising meal preparation.**

i. If meals are prepared in the unit, the staff member required pursuant to (c) above shall be present during food preparation and service.

ii. If meals are prepared off-site or catered, the unit administrator shall be responsible for the direction, provision and quality of dietary services and shall ensure that services conform to the standards of this chapter.

(d) If indicated in a patient's plan of care, an inpatient hospice care provider shall provide therapeutic or special diets.

(e) An inpatient hospice care provider shall have an approved dietary manual for reference when preparing meals.

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(f) A registered dietician or a registered nurse shall provide dietary counseling to patients who experience unmet nutritional needs.

8:42C-11.9 Laundry services for inpatient hospice care units

(a) Inpatient hospice care providers shall provide laundry services to meet the needs of each patient.

(b) If an inpatient hospice care provider contracts for laundry services, the inpatient hospice care provider must obtain a documented agreement from the contracted laundry service that details the services provided.

8:42C-11.10 Housekeeping services for inpatient hospice care units

(a) Inpatient hospice care providers shall provide housekeeping services to maintain an environment that is clean, sanitary and healthful.

(b) If an inpatient hospice care provider contracts for housekeeping services with an outside entity, the inpatient hospice care provider must obtain a documented agreement that details the services provided.

8:42C-11.11 Pets in inpatient hospice care units

(a) Inpatient hospice care providers shall have and implement policies and procedures to address:

- 1. Whether pets are permitted in a unit; and**
- 2. If pets are permitted:**
 - i. Mechanisms to assure staff and patient safety; and**
 - ii. Measures to prevent staff and patient discomfort.**

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8:42C-11.12 Emergency preparedness in inpatient hospice care units

(a) A unit shall have a written emergency preparedness plan.

1. Inpatient hospice care providers shall annually train all staff on the requirements of the written emergency preparedness plan.

2. Inpatient hospice care providers shall train all new staff members on the requirements of the written emergency preparedness plan within 30 days of commencement of duties within the unit.

(b) If a unit is located within a licensed healthcare facility, an inpatient hospice care provider shall coordinate emergency preparedness plans and drills with the licensed healthcare facility in which the unit is located.

(c) Inpatient hospice care providers shall conduct at least one drill of the emergency preparedness plan every month.

1. These 12 drills shall be conducted on a rotating basis to ensure that four drills occur during each working shift on an annual basis.

2. At least eight of the 12 drills shall be fire drills, and the remainder of the drills shall address other emergency preparedness situations.

8:42C-11.13 Health and safety laws for inpatient hospice care units

(a) Inpatient hospice care provider shall adhere to applicable Federal, State and local laws, regulations, and codes pertaining to health and safety, including provisions regulating:

1. Construction, maintenance and equipment for the hospice;

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- 2. Sanitation;**
- 3. Communicable and reportable disease; and**
- 4. Post mortem procedures.**

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