State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 358
TRENTON, N.J. 08625-0358
www.nj.gov/health

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

KAITLAN BASTON, MD, MSC, DFASAM
Commissioner

In Re:

THE VENETIAN CARE & REHAB CENTER
(NJ Facility ID# NJ12035)

INFORMATION REQUIREMENT ORDER

TO: Sandra Lowden, Administrator
The Venetian Care & Rehab Center
275 John T. Leary Boulevard
South Amboy, New Jersey 08879
SLowden@venetiancc.com

As more fully detailed below, the New Jersey Department of Health (the Department) hereby orders The Venetian Care & Rehab Center (Venetian) to submit to the Department information that is needed to ensure the health and safety of the residents in its care due to the identification of water management concerns at the facility involving the Legionella pathogen and the facility's failure to implement public health water management recommendations that would address those concerns.

The Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) (the Act) provides a statutory scheme designed to ensure that all health care facilities are of the highest quality. Pursuant to the Act and N.J.A.C. 8:43E-1.1 et seq. (General Licensure Procedures and Standards Applicable to All Licensed Facilities), the Commissioner of Health is authorized to inspect all health care facilities and to enforce the Standards for Licensure of Long-Term Care Facilities set forth at N.J.A.C. 8:39-1.1 et seq. Pursuant to N.J.S.A. 26:2H-5e, "[a]t the request of the commissioner, health care facilities shall furnish to the Department of Health and Senior Services such reports and information as it may require to effectuate the provisions and purposes of this act, excluding confidential communications from patients."

Legionella bacteria is a pathogen that can cause illness in humans and may grow and be distributed in community water systems. In October 2023, the Department's Communicable Disease Service (CDS) received a report of a Legionnaires' disease case in a long-term care resident at Venetian (Legionnaire's disease is a disease known to be caused by Legionella bacteria). Upon further investigation, it was determined that the case met the presumptive healthcare-associated case definition (i.e., > 10 days of continuous stay at a healthcare facility during the 14 days before symptom onset). One presumptive healthcare-associated case of Legionnaire's disease requires further investigation to determine if the facility is a source of Legionella exposure. The local health department (LHD) in the jurisdiction was responsible for conducting the outbreak investigation and is considered the "jurisdictional lead".

On November 15, 2023, CDS and LHD conducted an initial conference call with facility staff, during which interim recommendations and next steps were verbally provided to the facility. On November 17, 2023, the facility was provided with written interim recommendations that included:

- Hire a consultant and schedule a site visit
- Conduct water sampling for Legionella testing
- Implement water restrictions to protect patients (e.g., bottled water, 0.2-micron microbial filters on showerheads)

On November 27, 2023, the LHD sent an e-mail to the facility regarding the status of acquiring a consultant and scheduling a site visit. The facility responded that retention of a consultant had been delayed due to the holidays.

On January 25, 2024, a site visit took place at the facility to conduct an environmental assessment and provide additional recommendations regarding water management practices.

On February 7, 2024, CDS provided additional recommendations to the facility, including guidance for collecting water samples for Legionella testing and other water management practices.

On April 1, 2024, the facility conducted baseline water sampling for Legionella throughout their building water system. Four out of the 24 samples taken tested positive for Legionella.

On April 30, 2024, after receiving the Legionella testing results, CDS issued the following additional recommendations to the facility:

- Perform a chemical shock remediation of the building's potable water system
- Conduct post-remediation water sampling to assess the effectiveness (every 2 weeks for 3 months, then monthly for 3 months)
- Investigate factors promoting Legionella growth

On May 15, 2024, a third-party consultant hired by the facility conducted a chemical shock remediation.

On May 22, 2024, the facility conducted the first event of post-remediation water sampling for Legionella testing. On June 17, 2024, the LHD received the test results, which revealed that one of the 26 samples taken tested positive for Legionella.

On July 1, 2024, CDS followed up with the LHD regarding the status of testing at the facility. In July and August, the LHD sent multiple e-mails to the facility regarding the post-remediation testing, which should have been taking place every two weeks. The facility failed to respond.

On September 16, 2024, after several months without receiving environmental Legionella testing results, LHD, which had experienced a turnover in staffing during this time, reported an additional Legionnaires' disease case associated with the facility in a patient who died on September 15, 2024.

On September 23, 2024, CDS and LHD conducted a conference call with facility staff, at which time the facility notified CDS and LHD for the first time of additional testing that had occurred in June and July 2024, one of which revealed a significant increase in Legionella detection. Further, on October 3, 2024, the facility provided the results of testing from September 23, 2024, which once again revealed a significant increase in Legionella detection.

On October 8, 2024, CDS and LHD conducted a conference call with facility staff to discuss the recent results, at which time CDS recommended performing an in-depth environmental assessment to evaluate factors supporting Legionella growth in the building water system and performing another chemical shock remediation.

On October 16, 2024, a second chemical shock remediation was performed, which reset the sampling schedule to every two weeks for three months followed by monthly for three months.

On November 4, 2024, the facility shared documentation that a plumber had assessed the facility for deadlegs and reported that deadlegs would be removed that week. In response, the LHD inquired whether this was the complete environmental assessment and outlined what action items in an assessment are typically recommended by CDS. The facility failed to provide a comprehensive assessment despite many requests.

On November 5, 2024, first post-remediation Legionella testing results from water samples collected on October 2, 2024, revealed two out of 25 samples tested positive for Legionella.

On November 22, 2024, CDS notified the LHD reiterating the sampling guidance that needed to be adhered to, specifically following CDS's recommended sampling plan and sampling from locations with detectable levels of Legionella until those locations had three consecutive rounds of non-detectable results.

On November 26, 2024, post-remediation Legionella testing results from water samples collected on November 8, 2024, revealed nine out of 26 samples tested positive for Legionella, a significant increase from the last sampling event.

On December 16, 2024, post-remediation Legionella testing results from water samples collected on November 20, 2024, revealed five out of 26 samples tested positive for Legionella.

On January 21, 2025, post-remediation Legionella testing results from water samples collected on December 5, 2024, revealed five out of 26 samples tested positive for Legionella.

On January 29, 2025, CDS sent a follow up e-mail to the LHD because sampling should have been conducted every two weeks but neither CDS nor the LHD had received results in eight weeks.

On February 7, 2025, the LHD responded that the facility had failed to respond to e-mails and that a call to the facility revealed that the administrator had not been on site since the December 5, 2024, sampling event. The administrator advised the LHD that she would be contacting facility leadership.

On February 20, 2025, the LHD contacted CDS about the lack of cooperation from the facility. In response, CDS provided the LHD with language referencing NJ Senate Bill 2188 (an act concerning Legionnaires' disease and supplementing the Safe Drinking Water Act, N.J.S.A. 58:12A-1 et seq. and Title 26). The LHD provided this information to the facility and requested that the facility provide an action plan to implement testing protocols in accordance with public health recommendations to avoid an enforcement action. The facility did not respond until March 7, 2025, at which time the facility informed the LHD that the facility was being sold to another company on April 1, 2025, and that is why the facility had not been testing for Legionella.

The public health recommendations to address the Legionella include:

- Continuing to maintain recommended water restrictions throughout the investigation progress, such as point-of-use showerhead filters and avoiding use of tap water for any residents at risk of aspiration;
- Retaining the services of a third-party consultant for the full duration of the investigation and ensuring that the consultant has Legionella specific experience pertaining to water systems and remediation;
- Developing and implementing a written water management program adhering to ASHRAE Standard 188 and implementing control measures described in ASHRAE 12 and CDC's Legionella Control Toolkit;

- Conducting an environmental risk assessment to identify areas where Legionella could grow and spread through the building water systems; and,
- Continuing to assess the efficacy of the emergency remediation by collecting bulk water samples for Legionella culture testing, including speciation and serogrouping, from a CDC Elite Member laboratory, monitoring results, investigating root causes of Legionella growth and effectuating remediation.

INFORMATION REQUIREMENT ORDER

By April 21, 2025, Venetian shall provide to the Department information the following:

- A comprehensive water management plan providing for implementation of public health recommendations and the facility's timeline for implementation.

The information required pursuant to this order shall be emailed to: Lauren.Conner@doh.nj.gov, Stefaniej.Mozgai@doh.nj.gov, Michael.Kennedy@doh.nj.gov, Gene.Rosenblum@doh.nj.gov, Lisa.King@doh.nj.gov, and Jean.Markey@doh.nj.gov.

N.J.A.C. 8:43E-3.4(a)11 provides a $250 penalty for the failure to report information to the Department as required by statute or licensing regulation, after reasonable notice and an opportunity to cure the violation, which may be assessed for each day noncompliance is found.

Thank you for your attention to this important matter and for your anticipated cooperation. If you have any questions concerning this order, please contact Lisa King, Office of Program Compliance, at Lisa.King@doh.nj.gov.

Sincerely,

Lisa King, Program Manager
Office of Program Compliance
Division of Certificate of Need and Licensing

LK:JLM:nj
DATED: April 14, 2025
E-MAIL
REGULAR AND CERTIFIED MAIL
RETURN RECEIPT REQUESTED
Control #X25098

C. Order Service List