State of New Jersey
DEPARTMENT OF HEALTH
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PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

KAITLAN BASTON, MD, MSc, DFASAM
Commissioner

In Re Licensure Violation:	:	
Trinitas Adult Psychiatric Clinic	:	NOTICE OF ASSESSMENT OF PENALTIES
(NJ Facility ID# NJ1050)	:	

TO: Dr. Nancy DiLiegro-Administrator
Trinitas Adult Psychiatric Clinic
654 East Jersey Street
Elizabeth, New Jersey 07109
nancy.diliegro@rwjbh.org

Dear Dr. DiLiegro:

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 (the "Department") is authorized to inspect all health care facilities and to enforce the Hospital Licensing Standards set forth at N.J.A.C. 8:43G-1.1 et seq.

LICENSURE VIOLATIONS:

Staff from the Department of Health (Department) visited the Trinitas Adult Psychiatric Clinic (the Facility) on July 23, 2024, for the purpose of conducting a complaint survey.

The report of this visit, which is incorporated herein by reference, substantiated violations of the following:

The facility failed to ensure that staff do not physically abuse patients who are placed in a therapeutic hold during and after medication administration for agitation, failed to provide proper nursing care during the application of restraints, and failed to ensure appropriate monitoring and documentation of the effects of psychotropic medication, which shall not be used as a method of restraint. On July 18, 2024, a security officer punched a patient four times in the side of the head while the patient was restrained by two additional staff members, in violation of N.J.A.C. 8:43G-4.1(a)(18). The nurse failed to assess the patient after the administration of psychotropic medication and during the use of restraints, in violation of N.J.A.C. 8:43G-18.4(f) and (h).

N.J.A.C. 8:43G-4.1(a)(18) provides that "Every New Jersey hospital patient shall have the following rights, none of which shall be abridged by the hospital or any of its staff. The hospital administrator shall be responsible for developing and implementing policies to protect patient rights and to respond to questions and grievances pertaining to patient rights. These rights shall include at least the following:
....
18. To freedom from physical and mental abuse;"

The nurse failed to assess the patient after the administration of psychotropic medication and during the use of restraints, in violation of N.J.A.C. 8:43G-18.4(f) and (h).

N.J.A.C. 8:43G-18.4 provides that "Nursing care; use of restraints
....
(f) Interventions while a patient is restrained, except as indicated at (g) below, shall be performed by nursing personnel in accordance with nursing care policy. They shall include at least the following and shall be documented:
1. Assessment for clinical status and reevaluation of need for restraints at least every two hours;
2. Toileting at least every two hours with assistance if needed;
3. Monitoring of vital signs; and
4. Release of restraints at least once every two hours in order to:
i. Assess circulation and skin integrity;
ii. Perform skin care; and
iii. Provide an opportunity for exercise or perform range of motion procedures for a minimum of five minutes per limb.
5. Continuous or periodic visual observation based upon an evaluation of the patient's clinical condition.
6. Administration and monitoring of adequate fluid intake;
7. Adequate nutrition through meals at regular intervals, snacks, and assistance with feeding if needed;
8. Assistance with bathing as required, occurring at least once a day; and
9. Ambulation at least once every four hours if clinically feasible."

Finally, **N.J.A.C. 8:43G-18.4** provides that "Nursing care; use of restraints
...
(h) Registered professional nursing staff shall evaluate and ensure appropriate monitoring and documentation of the effects of all psychotropic medications. These medications shall be administered only upon written physician orders as part of the patient's treatment plan and shall not be used as a method of restraint, discipline, or for the convenience of staff. "

The facts substantiating the violations of these rules are set forth below.
On July 23, 2024, at 12:12 PM, review of video footage from the Psychiatric Emergency Services (PES) unit (view from inside of Room 2, Patient 1's room) recorded on July 18, 2024, was conducted in the presence

of the Vice President of the Behavioral Health Department, Director of Quality and Patient Safety, Vice President of Support Services, and the Security Manager. The Director of Quality and Patient Safety confirmed that the Vice-President of the Behavioral Health Department, Director of Quality and Patient Safety, Vice President of Support Services and Security Manager had previously watched the video footage. The Director of Quality and Patient Safety confirmed that the subject patient was present in the video and identified the staff members in the footage from July 18, 2024, PES Room 2. The Vice-President for Support Services indicated that the time stamps recorded in the video are two hours and 25 minutes behind the correct time. The video footage revealed the following:

At 4:27 AM (Timestamp: 2:02 AM), the subject patient appeared to be alone in PES Room 2 and was observed to be pacing in and out of camera view.

At 4:28 AM (Timestamp: 2:03 AM), The Mental Health Worker walked into the room with the patient, then the staff left.

At 4:42:03 AM (Timestamp: 2:17:03 AM), The Security Officer, Security Supervisor and the Mental Health Worker entered PES Room 2.

At 4:42:13 AM (Timestamp: 2:17:13 AM), The Registered Nurse entered Room 2.

At 4:42:20 AM (Timestamp: 2:17:20 AM), The subject patient walked towards the Mental Health Worker staff and swung his/her right fist towards the Mental Health Worker and appeared to have struck the staff member on the chin.

The Security Officer, Security Supervisor and the Mental Health Worker grabbed the patient and then brought his/her face down to the floor. The staff held the patient face down to the floor. The patient was kicking his/her legs. The Mental Health Worker was observed to be holding the Patient on the left side of the patient's head. The Security Supervisor was observed to be kneeling with his/her right knee in the center of the patient's back; and the Security Officer knelt beside the patient's right shoulder.

At 4:43:10 AM (Timestamp: 2:18:10 AM), the Security Officer, Security Supervisor, and the Mental Health Worker continued to restrain the patient who was face down on the floor.

The nurse appeared to administer an IM (intra-muscular) medication into the patient's gluteal muscle, then moved next to the patient's bed.

The Security Officer punched the patient four times with his/her closed fist, striking the patient each time in the right side of the head. An antenna was observed in the Security Officer's right hand while he/she punched the patient. After the fourth strike to the right side of the patient's head, the Security Officer threw a walkie-talkie radio from his/her right hand onto the patient's bed. The patient continued to kick his/her legs while still being restrained by the Security Officer, Security Supervisor and the Mental Health Worker.

At 4:43:54 AM (Timestamp: 2:18:54 AM), the patient stopped kicking his/her legs. The Security Officer, Security Supervisor and the Mental Health Worker continued to hold the patient while he/she remained face down on the floor. The Registered Nurse did not interact with or assess the patient, who was not observed to be moving.

At 4:44:17 AM (Timestamp: 2:19:17 AM), the patient kicked his/her legs then became motionless. The Security Officer, Security Supervisor and the Mental Health Worker continued to hold the patient's face down on the floor. The Registered Nurse was not looking towards the patient and began to check the restraints secured to the bed. The patient's vital signs were not assessed.

At 4:45:22 AM (Timestamp: 2:20:22 AM), the Security Officer, Security Supervisor and the Mental Health Worker picked up the patient's limp body and placed the patient face down towards the foot of the bed. The Registered Nurse did not assess the patient, who remained motionless. The patient's vital signs were not assessed.

At 4:45:53 AM (Timestamp: 2:20:53 AM), the patient was rotated toward the head of the bed, then turned onto his/her back. The patient remained motionless. The patient's vital signs were not assessed.

At 4:46 AM (Timestamp: 2:21 AM), the registered nurse performed a sternal rub on the patient, but the patient did not move. The Registered Nurse repeatedly touched the patient's face, and the patient remained motionless. The Registered Nurse also placed his/her hands on the patient's chest and performed five chest compressions. The patient's vital signs were not assessed.

At 4:46:32 AM (Timestamp: 2:21:32 AM), the patient began convulsing, as if he/she was having a seizure. The patient was turned onto his/her right side. The Registered Nurse rubbed the patient's back. The patient continued convulsing. The patient's vital signs were not assessed.

At 4:50:58 AM (Timestamp: 2:25:58 AM), the patient stopped convulsing and was observed to be moving. The Registered Nurse removed the patient's shirt. The patient was turned onto his/her back. Facility staff began to place restraints on the patient's ankle and wrists. The Registered Nurse wiped patient's face. The patient's vital signs were not assessed.

At 4:52:57 AM (Timestamp: 2:27:57 AM), the Registered Nurse climbed on top of the patient and laid across the patient's upper legs while staff placed the patient's left ankle, left wrist, and right wrist into restraints. The Registered Nurse then climbed off the patient. The patient's vital signs were not assessed.

At 4:53:20 AM (Timestamp: 2:28:20 AM), the Registered Nurse walked around the patient's bed and checked the restraints. All staff members, except the Mental Health Worker, exited the room. The Mental Health Worker sat in a chair away from the side of the patient's bed, while the patient remained in four-point restraints.

On July 23, 2024, at 12:25 PM, the Vice President of Support Services confirmed that the Security Officer punched the subject patient four times in the side of the head while the patient was being restrained. Upon interview at 1:05 PM, the Vice President of Support Services was asked what the expectation was when a staff member assaults a patient. He confirmed that the Security Officer received a "verbal warning" and returned to work on July 22, 2024, at 12:00 AM. The Vice President of Support Services stated that the Security Officer was "counseled by another Security supervisor prior to returning to work on July 22, 2024."

The Vice President of Support Services confirmed that the Security Officer did not receive any formal de-escalation re-education and was permitted to return to work while the incident was under investigation by the facility.

The Director of Quality and Patient Safety confirmed that the nurse did not respond to signs of patient distress or assess the patient at the time he/she became motionless on the floor after being placed in a physical hold by staff, and that the patient should have been assessed immediately once he/she became unresponsive.

Review of the medical record for the patient revealed that the nurse obtained a verbal order from a psychiatrist to administer diphenhydramine 50mg (milligrams); lorazepam 1mg; haloperidol 5mg IM (intramuscular) STAT (immediately) to the patient. The nurse explained that she did not assess the patient after administering the medication because, "The incident quickly changed from a psychiatric emergency to a medical emergency, then back to a psychiatric emergency. I've never had to perform CPR on a patient or had a patient have a seizure before this incident and I panicked. I know I messed up."

The Facility implemented its plan of correction on November 13, 2024.

The acts that violated **N.J.A.C. 8:43G-4.1(a)(18),** which guarantees New Jersey hospital patient rights, one of which is the freedom from physical and mental abuse, include, but are not limited to, the following:

- The Security Officer, Security Supervisor and the Mental Health Worker grabbed the patient and then brought his/her face down to the floor;
- Employees pinned the patient face down to the floor;
- The Mental Health Worker held the Patient on the left side of the patient's head restraining him/her;
- The Security Supervisor knelt with his/her right knee in the center of the patient's back;
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- The Security Officer punched the patient four times with his/her closed fist, striking the patient each time in the right side of the head with an antenna in the Security Officer's right hand while he/she punched the patient;
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- The Security Officer, Security Supervisor and the Mental Health Worker continued to hold the patient while he/she remained face down on the floor.
- The Registered Nurse did not interact with or assess the patient, who was not observed to be moving.

The Facility violated **N.J.A.C. 8:43G-18.4(f)** when the Patient's vital signs were not assessed after interventions while a patient is restrained.

The Facility violated **N.J.A.C. 8:43G-18.4(h)** when the nurse administered an IM (intra-muscular) medication into the patient's gluteal muscle which was administered without written physician orders as part of the patient's treatment plan and was used as a method of restraint, discipline, or for the convenience of staff.

MONETARY PENALTIES:

N.J.A.C. 8:43E-3.4(a)10 provides that for violations resulting in either actual harm to a patient or resident, or in an immediate and serious risk of harm, $ 2,500 per violation may be assessed for each day noncompliance is found. The Department is assessing a $2,500.00 penalty per day for the facility's failure to comply with N.J.A.C 8:43G-4.1(a)(18), N.J.A.C. 8:43G-18.4(f) and N.J.A.C. 8:43G-18.4 (h). Thus, a penalty

of $2,500 X 119 days, from July 18, 2024, which represents the date of the patient abuse and improper nursing care, to November 13, 2024, when the facility implemented its Plan of Correction, for a total penalty of $297,500. The lack of corrective action during the time of the incident until the implementation of the correction plan left patients at risk for immediate and serious harm warranting a per day $2,500.00 fine.

The Facility's failure to ensure that staff do not physically abuse patients who are placed in a therapeutic hold during medication administration for agitation, and its failure to assure proper nursing care during and after administration of psychotropic medication and during use of a restraint, resulted in actual physical harm to this patient and posed an immediate and serious risk of harm.

Therefore, the total penalty for these violations is $297,500 for violating N.J.A.C. 8:43G-4.1(a)(18), N.J.A.C. 8:43G-18.4(f) and N.J.A.C. 8:43G-18.4 (h).

The total amount of this penalty is required to be paid within 30 days of receipt of this letter by certified check or money order made payable to the "Treasurer of the State of New Jersey" and forwarded to Office of Program Compliance, New Jersey Department of Health, P.O. Box 358, Trenton, New Jersey 08625-0358, Attention: Lisa King. On all future correspondence related to this Notice, please refer to **Control AX24039.**

INFORMAL DISPUTE RESOLUTION (IDR):

N.J.A.C. 8:43E-2.3 provides facilities the option to challenge factual survey findings by requesting Informal Dispute Resolution with Department representatives. Facilities wishing to challenge only the assessment of penalties are not entitled to IDR review, but such facilities may request a formal hearing at the Office of Administrative Law as set forth herein below. Please note that the facility's rights to IDR and administrative hearings are not mutually exclusive and both may be invoked simultaneously. IDR requests **must be made in writing within ten (10) business days from receipt of this letter** and must state whether the facility opts for a telephone conference, or review of facility documentation only. The request must include an original and ten (10) copies of the following:

1. The written survey findings;

2. A list of each specific deficiency the facility is contesting;

3. A specific explanation of why each contested deficiency should be removed; and

4. Any relevant supporting documentation.

Any supporting documentation or other papers submitted later than 10 business days prior to the scheduled IDR may not be considered at the discretion of the IDR panel.

Send the above-referenced information to:

Nadine Jackman
Office of Program Compliance
New Jersey Department of Health

P.O. Box 358
Trenton, New Jersey 08625-0358

The IDR review will be conducted by professional Department staff who do not participate in the survey process. **Requesting IDR does not delay the imposition of any enforcement remedies.**

FORMAL HEARING:

The facility is entitled to contest the assessment of penalties pursuant to N.J.S.A. 26:2H-13, by requesting a formal hearing at the Office of Administrative Law (OAL). The facility may request a hearing to challenge any or all of the following: the factual findings and/or the assessed penalties. The facility must advise this Department within 30 days of the date of this letter if it requests an OAL hearing.

Please forward your OAL hearing request to:

Attention: OAL Hearing Requests
Office of Legal and Regulatory Compliance, New Jersey Department of Health
P.O. Box 360
Trenton, New Jersey 08625-0360

Corporations are not permitted to represent themselves in OAL proceedings. Therefore, if the facility is owned by a corporation, representation by counsel is required. In the event of an OAL hearing regarding the penalty, the facility is further required to submit a written response to each and every charge as specified in this notice, which shall accompany its written request for a hearing.

Failure to submit a written request for a hearing within 30 days from the date of this notice will render this a final agency decision. The final agency order shall thereafter have the same effect as a judgment of the court. The Department also reserves the right to pursue all other remedies available by law.

Thank you for your attention to this important matter and for your anticipated cooperation. If you have any questions regarding this Notice of Assessment, please contact Nadine Jackman, Office of Program Compliance, at Nadine.Jackman@doh.nj.gov.

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

LK:RSM:nj
DATE: April 21, 2025
E-MAIL: nancy.diliegro@rwjbh.org
REGULAR AND CERTIFIED MAIL, RETURN RECEIPT REQUESTED
Control# AX24039