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

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

In Re Licensure Violation:	:	
	:	
The Heritage Assisted Living	:	NOTICE OF ASSESSMENT OF
	:	PENALTIES
(NJ Facility ID# NJ 1A006)	:	
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TO: Edward Zirbser, Administrator(weaz@comcast.net)
The Heritage Assisted Living
45 Route 206
Hammonton, NJ 08037

Dear Mr. Zirbser:

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. Assisted living residence facilities are licensed in accordance with N.J.S.A. 26:2H-1 and N.J.A.C. 8:36. Pursuant to the Act and N.J.A.C. 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, and N.J.A.C. 8:43E, General Licensure Procedures and Standards Applicable to All Licensed Facilities, the Commissioner of the Department of Health (the "Department") is authorized to inspect all assisted living facilities and to enforce N.J.A.C. 8:36.

LICENSURE VIOLATIONS:

Staff from the Department of Health (Department) visited the Heritage Assisted Living (the facility) on June 10, 2022, for the purpose of a conducting a complaint survey. The report of this visit, which is

incorporated herein by reference, substantiated violations of N.J.A.C. 8:36-3.4(a)1, 4.1(a)16, 5.6(b)1-7, 10.4(a)1, 11.5 (e) and (f) and 11.6(a)4. N.J.A.C. 8:36-3.4(a)1 requires the administrator or designee to be responsible for ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights. N.J.A.C. 8:36-4.1 (a)16 provides that each resident has the right be free from physical and mental abuse and/or neglect. N.J.A.C. 8:36-5.6(b)1-7 requires the facility to provide all personnel with orientation at the time of employment and at least annual in-service education regarding, at a minimum, the following: the provision of assisted living services and assistance; emergency plans and procedures; infection prevention and control; resident rights; abuse and neglect; pain management; and the care of residents with Alzheimer's and related dementia conditions. N.J.A.C. 8:36-10.4(a)1 requires the facility to provide, according to the resident's needs, an assessment of the nutritional needs of the resident and, if indicated, requires the facility to prepare the dietary portion of the health care plan on the basis of the assessment, provide dietary services to the resident as specified in the dietary portion of the health plan, reassess the resident, and revise the dietary portion of the health care plan. N.J.A.C. 8:36-11.5(e) requires a registered professional nurse to report medication errors and to document medication errors in a resident's record. N.J.A.C. 8:36-11.5(f) requires a facility to administer medications accurately and requires authorized individuals to document the administration of medications in accordance with prescribed orders. N.J.A.C. 8:36-11.6(a)4 requires the facility's consultant pharmacist to review resident medication administration records on a quarterly basis. The facts substantiating the violations of these rules are set forth below.

On June 7, 2022, a surveyor interviewed a resident who stated there was a Home Health Aide (HHA) at the facility who was rude, nasty and had used foul language toward the resident. The resident stated that it began when the resident moved to the second floor around January 2022. Additionally, the resident stated that the HHA was rough and bumped the resident's wheelchair into an elevator wall and into the resident's apartment door when the HHA wheeled the resident to and from the dining room. The resident added that the HHA would take snacks from the resident's apartment without asking the resident. The resident also stated that the HHA would make the resident walk to the dining room for meals even when the resident told the HHA that walking for a long period of time was difficult due to knee discomfort. The resident told the surveyor that the HHA would say, "[t]hen you won't eat today." The resident told the surveyor that he/she missed a few meals for not being able to walk to the dining room. The surveyor asked if the resident had informed anyone about the incidents with the HHA. The resident stated that staff members, including the Executive Director (ED) and Wellness Director (WD), were aware of some of the issues with the HHA.

On June 8, 2022, a surveyor interviewed the WD regarding the resident's weights and requested the weights from October 2021 (date of admission) through June 2022. The WD provided the resident's weights as follows: in October 2021, upon admission the weight was 108 pounds (lbs.); in February 2022, the weight was 99 lbs.; in April 2022, the weight was 94 lbs.; in May 2022, the weight was 97 lbs.; in June 2022, the weight was 96 lbs. The resident's weight loss records indicated the resident lost twelve pounds between October 2021 and June 2022. The WD stated that she was not able to locate the resident's weights for November 2021, December 2021, January 2022, and March 2022. The WD explained that she was still new to the position and was not sure if the resident's weights for the above months were obtained. The survey also determined that the facility's Registered Nurse (RN) failed to consult a dietician to assess the nutritional needs of the resident who had sustained the weight loss. A review of the resident's medical record failed to identify any documentation that the nursing staff addressed the resident's weight loss from October 2021 to June 2022. The surveyor inquired from the RN the facility's protocol for weight loss, and the RN stated that the dietician was consulted when there were issues with weights. She stated that she was not aware that the resident had a 12 lb. weight loss and confirmed that

the resident had not been seen by a dietician. The surveyor reviewed the facility's weight policy, which stated that residents will be weighed monthly and that a dietician will be in every three months for weight management.

The surveyor inquired about the alleged staff to resident verbal abuse and asked when the WD had become aware of the resident's concerns. The WD stated that it was around April of 2022, when she overheard staff members discussing amongst themselves the resident and the HHA. The WD told the surveyor that she could not recall the staff members and that she re-assigned the HHA to a different assignment. However, the surveyor reviewed the facility assignment sheet dated May 1 through May 31, 2022, and observed that the resident continued to be assigned to the HHA on May 20, May 24, and May 27, 2022. The surveyor asked the WD if she spoke with the resident regarding what she overheard and whether she conducted an investigation. The WD confirmed that she did not interview the resident and that she did not conduct an investigation to rule out possible staff to resident abuse.

The surveyor reviewed the resident's medical record, which revealed that the resident's move-in date was October of 2021 and that the resident required a wheelchair for locomotion

The surveyor interviewed the WD in the presence of the ED and inquired about the staff member identified by the resident. The WD identified the HHA. During the interview, the ED stated that the HHA was verbally counseled regarding the resident's concerns, but it was not documented. The surveyor asked to speak with the HHA and the WD informed the surveyor that the HHA was suspended the morning of June 7, 2022, the date of survey, due to an incident with another employee. The HHA was not available for interview.

On June 8, 2022, the surveyor interviewed a Licensed Practical Nurse (LPN) regarding the HHA. The LPN told the surveyor that the HHA was a problem and was rude towards residents and other staff members and that nothing was being done about it. On June 15, 2022, the surveyor interviewed two patient care assistants (PCAs) who both stated that the resident told them that the HHA was rude, mean and used curse words/foul language. In addition, one of the PCAs stated that the resident told her that the HHA refused to take the resident to the dining room and ran the resident's wheelchair into the resident's apartment door. The surveyor asked both PCAs if Administration was made aware. One of the PCAs stated that she discussed the incident amongst other staff and could not recall if the WD was aware. The other PCA stated that she informed the WD but could not recall the exact date/month.

The facility also failed to investigate a potential act of abuse against a second resident. The surveyor reviewed the resident notes for the second resident, dated June 2, 2022, which revealed that a hospice aide noticed bruising on the resident's upper arms, and that the resident had not had a fall. The note stated that staff will continue to watch. During the surveyor's interview with the WD on June 7, 2022, the WD stated that she was informed by the hospice aide that the resident had bruising of the upper arm. The WD also stated that she was unsure how the resident sustained the bruise. The WD further stated that she had not initiated an investigation to rule out abuse.

The surveyor reviewed the facility's policy and procedure titled resident rights, which stated that the policy is to ensure resident rights are respected and protected at all times in compliance with all state and federal laws and that each resident has the right to be free from physical abuse, mistreatment, neglect and misappropriation of property. The policy also stated that all facility personnel are responsible for ensuring that resident rights are respected and maintained, and that the Administrator/designee is designated as the individual who conducts the investigation.

On June 7, 2022, the surveyor reviewed the personnel file of the HHA, hired on July 1, 2021, who was the subject of the alleged allegation of abuse. The personnel file did not contain any documentation that the HHA had received in-service training upon hire. The surveyor interviewed the ED regarding the employee's required in-service education/training. The ED stated that the HHA received the required training. However, he stated that the Human Resource (HR) personnel failed to complete the employee orientation checklist for the HHA upon completion of the new hire orientation. The surveyor interviewed the HR staff member responsible who stated that she completed the new hire orientation but forgot to complete the employee orientation checklist for the HHA. The facility failed to provide documented evidence confirming that the HHA received, upon date of hire, the required in-service training, including training on resident rights and abuse and neglect.

A surveyor reviewed the medication administration records (MAR) for two residents, which revealed that facility staff failed on numerous occasions to initial the MARs to indicate that medications were administered to these residents. The surveyor's review of the MARs for these residents revealed numerous instances in which prescribed diabetes medications for these residents were not charted as having been administered. The surveyor also determined that the facility failed to notify the prescribers and the facility's consultant pharmacist that the medications for these residents were not documented as being administered in accordance with prescriber's orders. The surveyor interviewed the facility's Wellness Director, who confirmed that the MARs records failed to document that diabetes medications were administered to these two residents in accordance with prescriber's orders. Disturbingly, the MARs records for one of the residents indicate no documentation that diabetes medications were administered to this resident on at least 50 different days, and the MARs records for the second resident indicate no documentation that 29 prescribed doses of diabetes medication were administered to the second resident. In addition, the survey determined that the facility's consultant pharmacist had not reviewed the MARs records for these two residents on a quarterly basis.

In summary, the survey determined that the facility failed to investigate and protect the rights of two residents to be free from verbal and physical abuse (N.J.A.C. 8:36-4.1(a)16), failed to address a resident's dietary needs and significant weight loss (N.J.A.C. 8:36-10.4(a)1), and failed to provide the required in-service training to an HHA (N.J.A.C. 8:36-5.6(b)1-7). The survey also determined that the administrator failed to enforce the facility's policies and procedures for prevention of abuse to two residents and failed to enforce the weight management policy for a resident. (N.J.A.C. 8:36-3.4(a)1). Lastly, the facility failed to comply with requirements for medication documentation, reporting of medication errors, administration of medication, and for review of resident records by the consultant pharmacist. (N.J.A.C. 8:36-11.5(e), 11.5(f), and 11.6(a)4).

MONETARY PENALTIES:

N.J.A.C. 8:43E-3.4(a)10 provides that the Department may assess a monetary penalty of $2,500 per violation, for violations resulting in either actual harm to a patient or resident, or in an immediate and serious risk of harm. The $2,500 may be assessed for each day noncompliance is found.

In accordance with N.J.A.C. 8:43E-3.4(a)10, and because the violations of the licensure regulations at N.J.A.C. 8:36-3.4(a)1, 4.1(a)16 and 10.4(a)1 resulted in actual harm to a resident and in an immediate and serious risk of harm, a $2,500 penalty is being assessed for each of four violations. The facility is assessed: $5000 due to its failure to investigate and protect the rights of two residents to be free from verbal and

physical abuse; $2500 due to its failure to address a resident's dietary needs and significant weight loss; and $5000 due to the administrator's failure to enforce the facility's policies and procedures to protect two residents. The penalty assessed for these violations is $12,500.

N.J.A.C. 8:43E -3.4(a)7 provides that the Department may assess a monetary penalty of $500 per violation for violations of licensure regulations related to patient care that represent a risk to the health, safety or welfare of resident of a facility or the general public. Because the violation of N.J.A.C. 8:36-5.6(b)1-7 represented a risk to the health, safety or welfare of a resident, the facility is assessed a $500 penalty due to its failure to provide the required in-service training to an HHA.

N.J.A.C. 8:43E-3.4(a)8 provides that the Department may assess a monetary penalty of $1,000 per violation for multiple deficiencies related to patient care throughout a facility, and/or such violations represent a direct risk that a patient's physical or mental health will be compromised, or where an actual violation of a resident's rights is found. The $1,000 may be assessed for each day noncompliance is found. The Department is assessing a $1,000 per day penalty for the facility's failure to comply with requirements for medication documentation, reporting of medication errors, administration of medication, and for review of resident records by the consultant pharmacist. (N.J.A.C. 8:36-11.5(e), 11.5(f), and 11.6(a)4). These violations of pharmacy requirements represented a direct risk that the physical health of two residents could be compromised. In accordance with N.J.A.C. 8:43E-3.4(b), and because of the expected deterrent effect of the penalty, the Department is reducing the per-day penalty for these violations to a $500 penalty for each of the 75 days when there was no documentation that the facility administered diabetes medications to two residents. The penalty for these violations is $37,000.

Therefore, the total penalty assessed for these violations under N.J.A.C. 8:43E-3.4(a)7, 8 and 10 is $50,000.

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 X21041.**

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 Heritage Assisted Living is entitled to challenge 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 Heritage Assisted Living may request a hearing to challenge any or all of the following: the factual survey findings and/or the assessed penalties. The Heritage Assisted Living must advise this Department within 30 days of the date of this letter if it requests an OAL hearing regarding the findings and/or penalty.

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

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.

Corporations are not permitted to represent themselves in OAL proceedings. Therefore, if the Heritage Assisted Living is owned by a corporation, representation by counsel is required. In the event of an OAL hearing, the Heritage Assisted Living is 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.

Finally, be advised that Department staff will monitor compliance to determine whether corrective measures are implemented by the Heritage Assisted Living to comply with N.J.A.C. 8:36-17.7. Failure to comply with these and any other applicable requirements, as set forth in pertinent rules and regulations, may result in the imposition of additional penalties. 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. Should you have any questions concerning this order, please contact Lisa King, Office of Program Compliance at (609) 376-7751.

Sincerely,

Gene Rosenblum
Director, Office of Program Compliance
Division of Certificate of Need and Licensing

DATE: November 22, 2022
FACSIMILE
E-MAIL (weaz@comcast.net)
REGULAR AND CERTIFIED MAIL
RETURN RECEIPT REQUESTED
Control # X21041