



State of New Jersey
DEPARTMENT OF HEALTH

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| In Re Licensure Violations: | : | |
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| Woodland Behavioral and Nursing Center | : | NOTICE OF VIOLATIONS, |
| | : | CORRECTIVE ACTION, |
| (NJ Facility ID# NJ 61901) | : | AND STATE MONITORING |
| | : | |
| | : | |
| | : | |

TO: Menachem Spiegel, Administrator
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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 Department's Commissioner 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.

Effective immediately, the Department of Health ("the Department") is issuing a Notice of Violations and Corrective Action to Woodland Behavioral Health and Nursing Center ("Woodland" or "the Facility"). In addition, the Department is appointing a state monitor to conduct a needs assessment and develop an analysis of the root causes of the current situation in the facility and provide a recommendation on what would be the most efficient and effective way to improve this facility so that it can safely care for residents into the future.

LICENSURE VIOLATIONS:

Staff from the Department's Health Facility Survey and Field Operations (HFS&FO) were on-site at Woodland Behavioral and Nursing Center (Facility) from January 3, 2022, through February 2, 2022. Based on observations, interviews, and review of pertinent Facility documentation the Facility failed to appropriately prevent abuse and neglect, with the deficiencies including:

1. Observations of Facility staff, including Certified Nurse Aides, revealed a phlebotomist verbally abused a resident on January 11, 2022, by cursing at him/her. Interviews with the Director of Nursing (DON) on January 21, 2022, revealed that she was aware of the allegation, and that the verbal abuse was witnessed by Facility staff, but there was no investigation of the abuse, and it was not reported to the New Jersey Department of Health (NJDOH) until the surveyor inquiry on January 21, 2022.
2. A Certified Nursing Aide (CNA) neglected a resident on January 11, 2022, by leaving him/her soiled in feces for ten hours from 11:00p.m. to 9:00/9:30a.m. the following morning despite the resident having a pressure ulcer wound to the sacrum. The resident reported that he/she informed the Staffing Coordinator that they no longer wanted the CNA because she made him/her "furious" and "scared." Interviews with the Staffing Coordinator revealed she was aware of the allegation of neglect and that the resident did not want care from the CNA anymore, but she failed to inform Facility administration or initiate an investigation into the allegation. Additionally, the Facility failed to investigate the allegation of neglect and never reported it to the NJDOH. The Facility never suspended the CNA pending the outcome of the investigation; the CNA continued to work over 36 shifts on 3 different units through January 31, 2022, after the allegation was made and prior to completion of any investigation. The CNA also continued to care for the resident on at least one additional shift after the neglect allegation.
3. A Licensed Practical Nurse (LPN) and a Quality Assurance Certified Nursing Aide (QA/CNA) neglected a resident after he/she called for assistance because his/her suprapubic catheter got stuck in a motorized wheelchair on January 16, 2022. The resident claimed it caused physical pain at the catheter site. The resident's pleas for help were ignored by the LPN and QA/CNA for over 40 minutes. An interview with the DON revealed she was aware of the incident, but she did not suspend the staff, investigate, or report the allegation of neglect to the NJDOH in accordance with the Facility's abuse policy even after being informed of the allegations of abuse and neglect on January 21, 2022. In addition, the Facility failed to suspend staff, initiate an investigation and report two other allegations of abuse to the NJDOH until January 27, 2022.

4. The surveyor witnessed verbal abuse from Facility staff towards a resident on January 26, 2022, when a CNA verbally abused the resident while in the room with the resident and in the presence of another CNA. The CNA pointed her finger at the resident, called the resident "manipulative," stated that he/she had "sneaky eyes" and stated in front of the resident that she was going to quit her job because of him/her. Another CNA was present in the room when this occurred, but the CNA did not immediately report the verbal abuse to Facility management. The resident stated that this made them feel angry and he/she wanted to leave the Facility.

The Facility's failure to appropriately prevent abuse and neglect, initiate investigations into the allegations of abuse and neglect, and its failure to suspend identified staff until the outcome of the investigation was complete in accordance with its Abuse Policy, posed a likelihood of serious mental anguish to the specific residents and other residents.

The survey team identified an Immediate Jeopardy for Cardiopulmonary Resuscitation-CPR. The deficiencies include:

1. During a review of closed death records, the Survey team identified that the Facility failed to activate its life-saving emergency response by immediately initiating Cardiopulmonary Resuscitation (CPR) when two full code residents were found unresponsive without pulses or respirations. One resident was a full-code and the family requested aggressive life-saving treatment despite medical decline. The resident progress notes revealed that the resident was last seen on October 8, 2021, within their baseline, and was found without a heartbeat and respirations one and a half hours from last being observed by staff. The resident was pronounced dead without the Facility initiating CPR, calling 911, or accessing the AED (defibrillator). Survey interviewed the Nurse assigned who claimed to be CPR-certified, but he/she did not implement CPR because the resident was "visibly blue," had a "locked jaw," and the Nurse thought the resident's physical signs meant the resident was "too far expired" and entered a state of irreversible death.

The other 55-year old resident was found to be unresponsive without a pulse or respirations on New Year's Day at 5:05 p.m., and was pronounced dead at 5:15 p.m., which was unexpected. The resident had last been seen one hour and thirty-five minutes prior and was within his/her baseline. According to documentation, the Facility never initiated CPR, called 911, or accessed the AED to provide life-saving measures. Furthermore, the resident had not been tested for COVID-19 since November 8, 2021, and there was no documented evidence that the resident had refused COVID-19 testing.

Interviews with the Nurse assigned to this resident claimed they were certified in CPR, and that they initiated CPR that day, but did not document it. However,

there was no evidence of CPR being administered, or a 911 call made to initiate life-saving interventions, which is the standard of practice for emergency resuscitation.

2. Survey's interview with the DON on January 28, 2022, revealed that the Facility did not maintain or track the CPR certifications of Facility staff and that the nursing staff involved would have to provide their CPR certificates from home.

The Facility's failure to appropriately initiate CPR, appropriately activate an emergency response, including calling 911 when residents were full code and found to be unresponsive without a heart rate and respirations, and the Facility's failure to maintain tracking of valid CPR certifications to ensure all shifts had staff who were certified in CPR, placed all residents at risk for imminent death if found unresponsive without a pulse and without respirations.

The survey team identified another Immediate Jeopardy for deficiencies that include:

1. During closed death record reviews, Survey determined that the Facility failed to ensure an unvaccinated resident at risk for serious outcomes from COVID-19 received necessary treatment to avoid their COVID-19 condition worsening, including hospitalization and death. The resident tested positive for COVID-19 on October 15, 2021, and the Facility failed to ensure the resident received Monoclonal Antibodies therapy infusion (Regeneron) in accordance with a STAT (immediate) order obtained from the Advanced Practice Nurse (APN) on October 17, 2021. The reconstituted intravenous infusion Regeneron was delivered to the Facility on October 17, 2021, at 10:02 PM, but it was not administered within the 36 hours of reconstitution as required for viability. The resident never received the STAT dose of Regeneron and the resident developed severe symptoms of COVID-19. The resident required hospitalization on October 21, 2021, with Acute Hypoxemic Respiratory Failure with COVID-19. The resident died on November 11, 2021.

The Facility failed to communicate with the acute care hospital that the resident never received the monoclonal antibodies, despite the STAT order from the APN. The Hospital Admission Evaluation record dated October 21, 2021, erroneously reflected that the resident had received the Monoclonal Antibody Infusion prior to admission to the hospital. However, record reviews and interviews with Facility staff (LPN, RN, APN) indicated the resident never received the infusion in accordance with the order.

2. The Facility failed to have a written policy related to the emergency-use FDA authorization for administration of the monoclonal antibody therapy, or evidence of staff education for the administration of monoclonal antibodies therapy infusion. According to the FDA, the Facility should have included specific administration instructions including monitoring during and after the infusion, the need for a specialized intravenous filter tubing for the infusion, and post-infusion

instructions for flushing the line to ensure complete administration of the therapy dose.

3. A second unvaccinated resident tested positive for COVID-19 on October 19, 2021. A review of the resident's Progress Notes dated October 20, 2021, revealed that the Infectious Disease (ID) physician recommended the Monoclonal Antibody infusion, and the resident consented, but the Facility failed to order it for two days until October 22, 2021. The doctor ordered the Monoclonal Antibody infusion STAT, but the order for Regeneron was never received or delivered by the pharmacy. The facility failed to verify receipt of the medication. The resident was not sent to the hospital to get the IV line or render the monoclonal antibody infusion. The resident was hospitalized for COVID-19 related illness on October 25, 2021. The resident died on November 6, 2021.

The Facility failed to identify that the residents never received the monoclonal antibodies infusions, and it failed to make the necessary corrective actions to prevent the failures from occurring again to any other residents scheduled to receive infusions.

The Facility's failure to implement reasonable measures, including policies and staff education to ensure timely monoclonal antibody infusions to prevent serious outcomes and death for all other residents that are prescribed monoclonal antibody infusions for COVID-19, placed all residents at risk for serious harm or imminent death.

The survey team identified another deficiency for failure to keep the Facility free of accidents and/hazards and failing to provide supervision to keep the Facility free of accidents and hazards. The deficiency is based on the following findings:

1. On January 21, 2022, during a medication storage follow-up on 3-Central Behavior Unit, the surveyor observed that the easily accessible, unlocked nurses' station had an unlocked emergency medication kit (e-Kit). The surveyor observed multiple, high-risk medications accessible to any wandering or potentially suicidal residents on the unit. The medications that were accessible included two tubes of Glucose for emergency use; two tablets of Vitamin K of 5 mg each (medication that can lead to cardiac arrhythmia), Nitrostat sublingual tablets; four (4) bottles of 60 mL Kayexelate solution (used to lower potassium levels in the blood and can dangerously affect the heart); and, three (3) pre-filled syringes of Lovenox (anticoagulant). The 3-Central Nurses' station is located central to the Behavioral Unit, where 23 active wandering residents and 3 residents with a history of suicidal ideations reside. The survey revealed that the nurses' station on 3-Central Behavioral Unit was not always supervised or staffed. On January 21, 2022, a unit clerk was present at the nurses' station and had no knowledge about the e-Kit or that the e-Kit had been unlocked. Unsupervised access to an unlocked e-Kit containing high-risk medications

without a system in place for the accountability of ensuring its location and the integrity of its locking mechanism placed all the residents who wander with cognitive impairment, advanced psychiatric illness or suicidal ideations at a serious risk for harm, impairment or death if a resident consumed or self-injected the medications.

2. The Facility had no system in place for accountability of the Facility e-Kits, including the integrity of the locking mechanism. Further investigation revealed that the e-Kit had been unlocked for four (4) days since January 17, 2022, when it had to be accessed to administer emergency resuscitative medications for a resident in apparent cardiac arrest.
3. The Facility failed to follow its policy for the e-Kit use, including to return and replace it immediately after opening.

The survey team notified the Licensed Nursing Home Administrator (LNHA) of the failure to provide administration. The failure to provide administration began on December 12, 2021, when the Facility was identified to be non-compliant with the requirement to provide infection control and prevention and for the failure to implement its COVID-19 Outbreak Response Plan and the U.S. Centers for Disease Control and Prevention (CDC) guidelines for mitigating transmission of COVID-19 in nursing homes. The LNHA's lack of oversight to ensure that the Facility's outbreak response plan was implemented during an influx of new COVID-19 cases amongst residents and staff (102 new staff cases and 131 new resident cases within a two-week period of time from December 23, 2021 to January 1, 2022) placed all residents at risk for contracting COVID-19. This deficiency is based on the following findings:

1. The LNHA's failure to appropriately hire or train a qualified Infection Preventionist (IP) in accordance with the Executive Directive 20-026 (updated January 6, 2021), failure to replace the IP with a qualified designee while she was out on leave during the peak of new COVID-19 infections, and the failure to implement minimum infection control standards in accordance with the CDC guidelines and the Facility's outbreak response plan, placed all residents at risk for contracting COVID-19. Furthermore, the LNHA failed to ensure adequate staffing or necessary cohorting of staff to prevent spread and failed to document/record any minutes related to infection control meetings or communications held related to the Facility's COVID-19 outbreak.
2. Observations and interviews conducted on January 5, 2022 and January 6, 2022 by the survey team revealed that Facility staff were not wearing or not properly wearing the necessary personal protective equipment (PPE) while on the COVID-19 units (no use of eye protection, improperly worn gowns or no use of gowns). There were multiple wandering residents on the COVID units who were COVID-19 positive, and they were not wearing masks. Additionally, there were

no receptacles for discarding used PPE at the exits of the four (4) COVID-19 positive units.

3. Observations and interviews conducted on January 3, 2022 through January 6, 2022 by the survey team revealed a unit which contained residents designated on all three COVID-19 cohort zones, well residents, persons under investigation (PUI) residents and COVID-19 positive residents. This included 5 of 6 PUI residents on that unit who were unvaccinated and not placed on Transmission-Based Precautions or placed in the proper cohort. The Facility commingled well residents with PUI and COVID-19 positive residents. Staff were unaware that the residents were supposed to be placed on Transmission-Based Precautions. Staff (housekeeper, housekeeping manager and LPN) assigned to that unit had no knowledge of a well-to-ill rounding and staff would see the COVID-19 positive resident/resident area first before resuming services for the non-COVID residents on the same unit. Observations by the survey team revealed that the housekeeper who had just cleaned the COVID-19 positive area exited the area with the same contaminated gloves and without performing hand hygiene. The housekeeper attempted to enter a non-COVID-19 resident room by coming in direct contact with the resident's doorknob and a surveyor had to intervene. The housekeeping manager confirmed that housekeepers clean the COVID-19 positive areas first before resuming services elsewhere in the building.
4. The Facility's LNHA failed to ensure that contact tracing was conducted and failed to ensure that unvaccinated residents who should have been PUIs were quickly identified and placed on transmission-based precautions (TBP) with all the appropriate PPE in accordance with CDC guidelines. This occurred on January 3, 2022, for 11 residents who tested positive for COVID-19 on a single, non-COVID (Green Zone) cohort zone, who had not been previously identified as exposed to COVID-19. The Facility's LNHA did not ensure the implementation of transmission-based precautions for the remaining residents on the unit to mitigate the spread of COVID-19 when they could not clearly identify how those residents may have been exposed to COVID-19.
5. The LNHA confirmed that staff who cared for residents who tested positive for COVID-19 and residents considered PUI needed to wear personal protective equipment including gloves, gown, eye protection, and an appropriately worn N95 mask to prevent the spread of COVID-19. Staff were unaware of proper protocol of exposure and implementation of TBP to prevent the spread of infection.
6. Residents who have been exposed to COVID-19 have the potential to be COVID-19 positive and asymptomatic. Staff caring for these residents are unaware of these residents' exposure and could potentially further spread COVID-19 through not maintaining TBP. COVID-19 is known to be a highly infectious communicable disease that can lead to death. The lack of oversight to

ensure that the Facility's Outbreak Response Plan has been implemented during its COVID-19 outbreak and a system in place for identifying breaches in infection control and implementing corrective actions (Quality Assurance Performance Improvement plan) placed all the residents at risk for developing COVID-19. As of February 2, 2022, 14 resident of Woodlands who tested positive for COVID-19 during this outbreak have died.

The survey team identified another deficiency for the failure to implement a quality assurance and performance improvement plan. The deficiency is based on the following findings:

1. On January 21, 2022, during an investigation into the Facility's plan and practices, survey staff identified that the Facility had not formulated and implemented a QAPI plan to address any area related to infection prevention and control prior to and during their COVID-19 outbreak. The Facility had no system for identifying concerns related to infection prevention and control and there was no documented evidence of an identified area in need of sustaining or improvement, a measurable goal/benchmark, a written infection control implementation plan with audits, or a good faith effort of monitoring to evaluate for improvements related to infection control practices.
2. Interviews by survey staff with the Infection Preventionist who had been employed at the Facility since June 2021 revealed that she had not attended any QAPI Meetings and was not included or involved in the QAPI process, as is required. She was not aware of any designated staff either.
3. A review of Infection Control Meeting Minutes conducted on July 13, 2021 and October 26, 2021 revealed a brief report on employee health and the COVID-19 status of the Facility, but did not address a QAPI or any related infection control improvement efforts.
4. The LNHA did not have any documented evidence of meeting minutes for infection prevention and control prior to the onset of the COVID-19 outbreak that began in September 2021, and there was no evidence of a root-cause analysis/evaluation to determine possible causes for the significant increase of COVID-19 cases amongst residents, or of an effort to evaluate infection control measures or of reviewing other processes including COVID-19 testing. The Facility's LNHA and its Infection Preventionist were unable to provide any documentation to demonstrate a good faith attempt for any QAPI related to infection prevention and control.
5. Prior to the Facility's COVID-19 outbreak, there was no QAPI/written plan for infection prevention and control to monitor and evaluate the Facility's efforts or progress. Upon the start of the Facility's COVID-19 outbreak, and with the knowledge of a significant increase in COVID-19 cases, the Facility failed to

show evidence of an attempt to identify a root-cause for the rapid spread of COVID-19 amongst residents and staff and a means to further mitigate the spread of COVID-19. Without a system to self-identify possible infection control concerns, infections are likely to spread. As of February 2, 2022, the Facility had 14 deaths of residents who had tested positive for COVID-19 during this outbreak, and there was no QAPI for infection prevention and control in place prior to or during this outbreak until surveyor inquiry.

The survey team also identified a deficiency for the failure to provide infection prevention and control. The deficiency is based on the following:

1. The Facility failed to implement its outbreak response plan and the CDC guidelines regarding preventing the spread of COVID-19 in nursing homes. Furthermore, the Facility's Outbreak Response Plan did not address contact tracing. Residents who have been exposed to COVID-19 have the potential to be COVID-19 positive and asymptomatic. Staff caring for these residents are unaware of these residents' exposure and could potentially further spread COVID-19 through not maintaining TBP.
2. From December 23, 2021 through January 6, 2022, 102 Facility staff members tested positive for COVID-19 when the Facility and their Infection Preventionist (LPN/IP) stopped conducting contact tracing to identify residents exposed to COVID-19. The Facility's failure to identify residents exposed to COVID-19 and failure to place the unvaccinated residents on transmission-based precautions through the means of contact tracing to mitigate its transmission during their COVID-19 outbreak, placed all the residents in the Facility at risk of contracting COVID-19.
3. Observations and interviews conducted by the survey team on January 5, 2022 and January 6, 2022 revealed that Facility staff were not wearing or properly wearing the necessary PPE while on the COVID-19 units (no use of eye protection, improperly worn gowns or no use of gowns), and that there were multiple wandering residents who tested positive throughout the units who were not wearing appropriate PPE. Additionally, there were no receptacles for discarding used PPE upon at the exits of the 4 COVID-19 positive units.
4. Interviews with nursing staff by the survey team on a COVID-19 positive unit revealed that some of the staff float to various units/cohort zones, including taking on assignments for residents who were not positive for COVID-19.
5. Observations by the survey team of staff (CNA, housekeeper, Security Guard) revealed that they were improperly wearing an N95 respirator mask (surgical mask worn under the N95 mask), despite the claim to have been fit-tested for the mask.

6. Observations and interviews conducted on January 3, 2022 through January 6, 2022 by the survey team revealed a unit which contained residents designated on all three COVID-19 cohort zones, well residents, PUI residents and COVID-19 positive residents. This included 5 of 6 PUI residents on that unit who were unvaccinated and not placed on Transmission-Based Precautions or placed in the proper cohort. The Facility commingled well residents with PUI and COVID-19 positive residents. Staff were unaware that the residents were supposed to be placed on Transmission-Based Precautions. Staff (housekeeper, housekeeping manager and LPN) assigned to that unit had no knowledge of a well-to-ill rounding and staff would see the COVID-19 positive resident/resident area first before resuming services for the non-COVID residents on the same unit. Observations by the survey team revealed that the housekeeper who had just cleaned the COVID-19 positive area exited the area with the same contaminated gloves and without performing hand hygiene. The housekeeper attempted to enter a non-COVID-19 resident room by coming in direct contact with the resident's doorknob and a surveyor had to intervene. The housekeeping manager confirmed that housekeepers clean the COVID-19 positive areas first before resuming services elsewhere in the building.
7. Furthermore, the Facility's designated, full-time Infection Preventionist/LPN did not meet the State-mandated qualifications to act as the Facility's IP, in accordance with Executive Directive 20-026, updated January 6, 2021.
8. In addition, there was no documented evidence of monitoring for signs and symptoms of COVID-19 for residents that were PUI or positive for COVID-19, including for residents leading up to hospitalization and expiration.
9. The Facility failed to perform contact tracing, failed to identify PUI residents, failed to implement TBP including appropriate PPE, failed to use N95 masks, goggles, TBP signs to indicate the residents exposed to the staff that tested positive and to provide the necessary PPE bins on all units. Specifically, this occurred on January 3, 2022, when 11 residents who tested positive for COVID-19 on a single, non-COVID (Green Zone) Cohort when they had not been previously identified as exposed to COVID-19. The Facility did not implement transmission-based precautions for the remaining residents on the unit to mitigate the spread of COVID-19 when it could not clearly identify how those residents may have been exposed to COVID-19.
10. The LNHA confirmed that staff who cared for residents who tested positive for COVID-19 and residents considered PUI needed to wear personnel protective equipment including gloves, gowns, eye protection, and an appropriately worn N95 mask to prevent the spread of COVID-19. Staff were unaware of proper protocol of exposure and implementation of TBP to prevent the spread of infection.

The survey team identified another violation for the failure to provide COVID-19 testing of residents and staff. The deficiency is based on the following findings:

1. During a review of COVID-19 testing for residents and staff, the survey team identified that the Facility failed to consistently perform bi-weekly COVID-19 testing for vaccinated and unvaccinated staff and residents during their COVID-19 outbreak when contact tracing could not be implemented, and in accordance with the Facility's Outbreak Response Plan, the Facility's Testing Policy and Procedure, and CDC guidance to mitigate the spread of the COVID-19 virus.
2. The Facility failed to provide sufficient and consistent evidence of tracking COVID-19 testing for residents and staff which was likely to delay identification of residents and staff who could have been positive for the COVID-19 virus.
3. The Facility failed to keep an accurate record of staff who were partially vaccinated and unvaccinated for COVID-19 to ensure testing was done for the required individuals. Specific dates the Facility was unable to provide evidence of testing or results of COVID-19 testing for any staff included: November 12, 2021 through December 6, 2021 and December 29, 2021 through January 10, 2022, and January 13, 2022 through January 26, 2022.
4. Two residents that had expired had no evidence of COVID-19 testing in accordance with required time frames; one resident who did not have the booster and received their second dose of the COVID-19 vaccine on June 3, 2021 had not been tested since August 5, 2021 and expired on October 8, 2021; and another resident who did not have the booster and received their 2nd dose of the vaccine on February 16, 2021 had not been tested for COVID-19 since November 8, 2021 and expired on January 1, 2022. There was no documented evidence that either of the residents had refused COVID-19 testing. An interview with an unvaccinated CNA revealed that the Facility had stopped testing for COVID-19 for a period of time in November 2021, but she could not explain why this was the case.
5. Interviews with the Facility's Infection Preventionist indicated that the Facility was not appropriately tracking staff and residents who were tested for COVID-19. The Infection Preventionist stated that she was unable to tell the survey team which residents and staff members were tested for COVID-19 upon review of the information provided by the Facility. The Infection Preventionist further stated that she was unaware of a staff member working at the Facility that would be able to speak to COVID-19 testing for residents and staff. No other information was provided by the Licensed Nursing Home Administrator.
6. The Facility's failure to ensure that COVID-19 testing was performed in accordance with CMS requirements and CDC guidelines for vaccinated and unvaccinated staff and residents in a timely manner delayed the identification of

COVID-19 positive residents and staff, which impacted the ability to promptly cohort residents and prevent the further spread of COVID-19. As of February 2, 2022, the Facility had 14 deaths of residents who had tested positive for COVID-19 since the onset of its most recent COVID-19 outbreak.

The survey team identified a state violation based on the following findings:

1. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 7 of 14 evening shifts and deficient in total staff for residents on 10 of 14 overnight shifts as follows:
 - a. 12/19/21 had 37 CNAs for 458 residents on the day shift, required 58 CNAs.
 - b. 12/19/21 had 41 total staff for 458 residents on the evening shift, required 46 total staff.
 - c. 12/19/21 had 25 total staff for 458 residents on the overnight shift, required 33 total staff.
 - d. 12/20/21 had 43 CNAs for 458 residents on the day shift, required 58 CNAs.
 - e. 12/21/21 had 48 CNAs for 458 residents on the day shift, required 58 CNAs.
 - f. 12/22/21 had 43 CNAs for 458 residents on the day shift, required 58 CNAs.
 - g. 12/23/21 had 41 CNAs for 463 residents on the day shift, required 58 CNAs.
 - h. 12/24/21 had 37 CNAs for 463 residents on the day shift, required 58 CNAs.
 - i. 12/24/21 had 39 total staff for 463 residents on the evening shift, required 47 total staff.
 - j. 12/24/21 had 27 total staff for 463 residents on the overnight shift, required 34 total staff.
 - k. 12/25/21 had 39 CNAs for 462 residents on the day shift, required 58 CNAs.

- i. 12/25/21 had 41 total staff for 462 residents on the evening shift, required 47 total staff.
- m. 12/25/21 had 25 total staff for 462 residents on the overnight shift, required 33 total staff.
- n. 12/26/21 had 23 CNAs for 461 residents on the day shift, required 58 CNAs.
- o. 12/26/21 had 38 total staff for 461 residents on the evening shift, required 47 total staff.
- p. 12/26/21 had 23 total staff for 461 residents on the overnight shift, required 33 total staff.
- q. 12/27/21 had 32 CNAs for 460 residents on the day shift, required 58 CNAs.
- r. 12/27/21 had 43 total staff for 460 residents on the evening shift, required 46 total staff.
- s. 12/27/21 had 21 total staff for 460 residents on the overnight shift, required 33 total staff.
- t. 12/28/21 had 32 CNAs for 460 residents on the day shift, required 58 CNAs.
- u. 12/28/21 had 24 total staff for 460 residents on the overnight shift, required 33 total staff.
- v. 12/29/21 had 34 CNAs for 458 residents on the day shift, required 58 CNAs.
- w. 12/29/21 had 30 total staff for 458 residents on the overnight shift, required 33 total staff.
- x. 12/30/21 had 29 CNAs for 457 residents on the day shift, required 58 CNAs.
- y. 12/30/21 had 25 total staff on the overnight shift, required 33 total staff.
- z. 12/31/21 had 28 CNAs for 455 residents on the day shift, required 57 CNAs.

- aa. 12/31/21 had 36 total staff for 455 residents on the evening shift, required 46 total staff.
- bb. 12/31/21 had 22 total staff on the overnight shift, required 33 total staff.
- cc. 01/01/22 had 31 CNAs for 453 residents on the day shift, required 57 CNAs.
- dd. 01/01/22 had 37 total staff for 453 residents on the evening shift, required 46 total staff.
- ee. 01/01/22 had 19 total staff for 453 residents on the overnight shift, required 33 total staff.

This letter reflects Federal deficiencies, and a State Licensure report will also be issued. You will receive a complete inspection report detailing all deficiencies.

CORRECTIVE ACTION :

The above-referenced violations pertain to the care of residents and to hazardous and unsafe conditions existing in the Facility. In accordance with N.J.S.A. 26:2H-14 and N.J.A.C. 8:43E-3.8, the Department hereby notifies Woodland that it shall have 72 hours in which to correct the violations. If the violations are not corrected within 72 hours and continue to pose an immediate threat to the health, safety or welfare of the public or the residents of the Facility, then the Department will issue a notice of summary suspension of Woodland's license, which will provide a time period to effect an orderly transfer of residents, and order immediate correction of any violations as a prerequisite to reinstatement of the license.

The Facility shall:

1. Submit an acceptable plan of correction within ten days of receipt of the final statement of deficiencies and comply with the plan of correction;
2. Comply with the Directed Plans of Correction and Curtailment of Admissions, as set forth below;
3. Fully cooperate with the state monitor, as set out below; and,
4. Within 72 hours, correct the violations outlined above pertaining to the care of residents or to the hazardous or unsafe conditions of the physical structure that pose an immediate threat to the health, safety, and welfare of the public or the residents of the facility.

STATE MONITORING:

The Department will select a management consulting firm with expertise in nursing home administration, finance and clinical operations (the "Monitor"). The Monitor shall be engaged at the Department's expense and shall complete the following tasks, at a minimum:

1. Conduct a general assessment of operations, including contracts and leases, and infrastructure of the facility. The assessment does **not** need to include a physical plant/life safety code assessment. The infrastructure assessment will include identifying if the current layout and design of the facility meets the needs of the residents into the future;
2. Report on the delivery of all services, including which services are contracted and the relationship between the contractors and the owners of the facility, inclusive of financial arrangements;
3. Conduct an analysis of the care needs of the residents and write an evaluation of whether these needs can be met by the facility's current operations plan;
4. Develop a closure plan for the facility and develop a plan for safe and effective care of the residents in the event of a change of ownership or in the event the Department summarily suspends or revokes the facility's license based upon the facility's failure to correct the violations (to include discharge planning that complies with State and federal regulatory requirements);
5. Develop an analysis of the root causes of the current situation in the facility and provide a recommendation on what would be the most efficient and effective way to improve this facility so that it can safely care for residents into the future; and,
6. Provide weekly updates to the Department including recommendations made to the facility and the facility's response to the recommendations.

In carrying out these responsibilities, the monitor shall: i) have full access to any and all records and information at Woodland in order to gain an understanding of the prior and current level of care provided, as well as the financial decisions of Woodland, ii) have full access to the senior management team and staff to determine, among other things, how strategic and resident care decisions are made; iii) have full access to brief the facility's owners and senior management as a group or individually, and iv) report to the Commissioner of the Department of Health to facilitate the regulatory relationship.

The appointed monitor shall provide all of its reports, findings, projections, operational and strategic plans to the Commissioner on or before the 90th day from the appointment.

CURTAILMENT OF ADMISSIONS AND DIRECTED PLAN OF CORRECTION:

On January 11, 2022, the Department issued an order curtailing all admissions to the Facility, excluding readmissions. In addition, the Department issued a Directed Plan of Correction requiring the Facility to retain an Administrative Consultant and to submit a plan detailing the steps it would take to meet state staffing requirements. On January 14, 2022, the Department issued an Amended Directed Plan of Corrections requiring the Facility to retain a Registered Nurse Consultant and Certified Infection Control Practitioner Consultant. The Curtailment, Directed Plan of Correction and Amended Directed Plan of Correction shall remain in place until the Facility is otherwise notified in writing by a representative of the Department.

STAFFING:

Staffing at the Facility must meet the needs of the residents in accordance with state law, including N.J.S.A. 30:13-18.

RIGHT TO HEARING:

In the event the Department issues the Facility a summary suspension, the Facility will have a right to a hearing consistent with N.J.S.A. 26:2H-14.

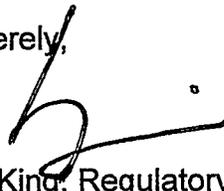
NOTIFICATION:

The facility shall notify residents, family members and guardians by providing them with a copy of this Notice of Violations, Corrective Action and State Monitoring within 72 hours of receipt. The facility shall maintain a record of such notifications which shall be available for inspection by the Department and Monitor.

Department staff will monitor compliance with this notice to determine whether corrective measures are implemented by Woodland. Failure to comply with these and any other applicable requirements, as set forth in pertinent rules and regulations, may result in the imposition of 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 matter, please contact Lisa King, Office of Program Compliance at (609) 376-7751.

Sincerely,



Lisa King, Regulatory Officer

Woodland Behavioral and Nursing Center
Notice of Violations, Corrective Action and State Monitoring
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Division of Certificate of Need and Licensing
Office of Program Compliance

LK:GR:JLM:MJ:WCK:jb

DATE: February 10, 2022
FACSIMILE (201) 967-7336
E-MAIL (mspiegel@woodlandbehavioral.com)
REGULAR AND CERTIFIED MAIL
RETURN RECEIPT REQUESTED
Control # 21031