



**State of New Jersey**  
**DEPARTMENT OF HEALTH**

PO BOX 367  
TRENTON, N.J. 08625-0367

[www.nj.gov/health](http://www.nj.gov/health)

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SHEILA Y. OLIVER  
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*Commissioner*

In Re Licensure Violation:

WOODLAND BEHAVIORAL  
AND NURSING CENTER  
(NJ Facility ID# NJ61901)

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CURTAILMENT OF  
READMISSIONS

TO: Menachem Spiegel, Administrator  
Woodland Behavioral and Nursing Center  
99 Mulford Road  
PO Box 1279  
Andover, New Jersey 07821

As you were notified verbally on May 19, 2022, effective upon the facility's verbal notification, the Department of Health (hereinafter, "the Department") ordered the curtailment of readmissions to Woodland Behavioral and Nursing Center (hereinafter "Woodland"). This enforcement action was taken in accordance with the provisions set forth at N.J.A.C. 8:43E-2.4 (Plan of Correction), 3.1 (Enforcement Remedies Available) and 3.6 (Curtailment of Admissions) in response to serious deficiencies observed by Department staff at Woodland during its on-site inspection.

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.

## **LICENSURE VIOLATIONS:**

Staff from the Department of Health's Health Facility, Survey and Field Operations were on-site at Woodland for a complaint survey beginning May 11, 2022, in response to a referral from Atlantic Health (State-Appointed Monitor). During the survey, the survey team identified deficient practices in tube feeding management that posed an immediate and serious risk of harm to the residents of Woodland. During the course of investigating the impaction and dehydration of Resident #2, it was determined the facility failed to ensure a resident reliant on a nutrition and hydration through a feeding tube received the necessary care and services to prevent weight loss, recurrent dehydration and impaction.

Resident #2 was admitted to the facility in 2017 with a diagnosis of constipation and had multiple recent hospitalizations. The resident was hospitalized on January 19, 2022, with a large volume of stool in the colon resulting in obstruction. The resident was readmitted to the facility on January 25, 2022, and there was no documented comprehensive nutrition evaluation/assessment by the registered dietitian to determine the resident's baseline nutritional needs and goals.

On January 26, 2022, the resident had physician orders for Fibersource 70 mL/hour for a total volume of 1000 mL. The enteral feeding sheet did not account for a total volume infused, and nurses were just signing every shift that the tube feeding was running. There was an order to administer 200 mL of free water flushes every six hours (this equates to 4 times a day), but there were no specific times for the flushes to be administered on the enteral feeding sheet, as it was only plotted by shift (day, evening and night, which is only 3x/day). Gastric feeding residuals were documented as scribbles, which did not clearly indicate if the volumes were zeros or any other volume.

Resident #2 was hospitalized again on February 23, 2022, and a CT scan on February 24, 2022, revealed that the resident had constipation with fecal impaction not excluded. The resident was admitted to the hospital with dehydration, and per the hospital records, was so "severely constipated" that Colace, Sennakot and Lactulose were not effective for producing a bowel movement, and Magnesium Citrate and an enema had to be administered with a positive effect. The hospital records revealed a belief that the resident had been refusing the tube feeding and hydration, but facility documentation and interviews revealed that the resident was allegedly compliant with nutritional feedings. The Tube Feeding Formula changed to Nutren 1.5 (which is a fiber-free formula).

Resident's height was 66 inches (5'5), and was on weekly weights, and started at 109 lbs in January 2022. Resident was consistently losing 2-4 lbs/week on nutritional tube feeding formula that should have been resulting in weight gain, but there was no documented justification for the ongoing weight loss by the Registered Dietitian, physician or other medical professional.

Resident #2 was readmitted to the facility on February 27, 2022, without evidence that staff had reviewed the hospital records, which revealed dehydration and impaction. There were no changes in the resident's plan of care specific to bowel management and abdominal assessments to prevent recurrence.

The resident suffered another impaction on May 2, 2022, and, at the hospital, the CT scan revealed that the impaction was causing a "risk for perforation," and 2 pints of blood had to be transfused. Facility nursing staff (admission nurse, nurses, nursing supervisors, Director of Nursing, Registered Dietitian) all revealed that they did not review the hospital records during the readmission to the facility on BOTH January 25<sup>th</sup> and February 27<sup>th</sup> and had no knowledge that the resident had ever been impacted in the hospital. As a result, on both re-admissions, there was no plan of care initiated to prevent another episode of constipation and impaction, and the resident had another impaction and required re-hospitalization on May 2, 2022.

Interviews with the Registered Dietitian revealed that if the Resident was receiving all hydration and nutrition in accordance with the physician's order, there would be no possible way for Resident #2 to lose weight or become impacted because what was ordered allegedly exceeded 100% of the resident's needs. The Registered Dietitian stated that they did not think the resident was receiving the nutrition and hydration because otherwise the resident "wouldn't be losing weight."

The Registered Dietitian never identified the impaction until the surveyors brought it to the Registered Dietitian's attention.

Further, when the facility was notified by the hospital of the resident's impaction and dehydration on May 5, 2022, it initiated a Quality Assurance and Performance Improvement process, but it did not conduct an investigation into the possible causes of the hospitalizations and diagnoses of impaction and dehydration in order to rule out neglect and determine if the resident was receiving all hydration and nutritional feedings.

The team identified a second resident (Resident #4) who had a gastrostomy tube and was identified to have a bowel impaction on April 6, 2022, upon transfer to the hospital. Leading up to the impaction, the March 2022 bowel movement accountability log included many blanks, and was blank from March 26 to April 3, 2022. There was no bowel movement on April 4<sup>th</sup> or April 5<sup>th</sup>, and the resident was hospitalized on April 6<sup>th</sup>. At the hospital the resident received treatment for an impaction AND aspiration pneumonia (which the surveyors concluded was likely a result of the impaction because the tube feeding had nowhere else to go if the colon was blocked with impacted stool, except back up through the oral cavity and down to the lung).

Despite the bowel logs revealing blanks throughout March 2022 and no evidence of bowel movements, the resident never received an as-needed bowel regimen medication. There

was no care plan to address a risk for constipation, actual constipation, or that the resident had an impaction.

Hydration records revealed that the resident had Free-water flushes that were supposed to be manually administered 200 mL every 4 hours around the clock (6x/day), but the order for the free-water flushes were not timed in the Enteral Administration Records. They were only timed to be infused per "shift," therefore nurses were only signing for the flushes for their shift (which is 3x/day instead of the 6x/day as ordered) (This would account for a deficit of at least 600 ml of water every day).

The Physician/Medical Director completed a History and Physical upon the resident's return to the facility and documented that the resident had a "fecal impaction," but he never ensured that the resident was put on any form of bowel regimen/medication or reviewed the hydration to ensure an impaction did not occur again for this resident. The Physician/Medical Director's knowledge of the fecal impaction and failure to order medications or interventions to prevent recurrence, placed this resident at an immediate risk of serious harm, impairment, or death. The Physician/Medical Director never advised the facility to investigate the fecal impaction of this resident to rule out neglect.

These identified deficient practices in tube feeding management posed an immediate and serious risk of harm to the residents on feeding tubes. The surveyors found that there was no facility policy for tube feeding management accountability to ensure residents received the necessary nutrition/hydration.

Impaction can lead to severe pain, perforation, sepsis and death. Failure to provide necessary tube feeding management and nutrition/hydration management can result in significant weight loss, dehydration, impaction, and death.

#### **CURTAILMENT OF READMISSIONS:**

On January 11, 2022, the Department issued an order curtailing all admissions to the Facility, excluding readmissions. The Department now orders the curtailment of readmissions, effective upon the facility's verbal notification on May 19, 2022. This curtailment of readmissions shall remain in place until the facility is otherwise notified in writing by a representative of this Department.

Department staff will monitor facility compliance with this order, and failure to comply may result in the imposition of penalties. N.J.A.C. § 8:43E-3.4(a)(2) provides for a penalty for each resident admitted in violation of this curtailment order.

#### **FORMAL HEARING:**

Woodland is entitled to contest the curtailment by requesting a formal hearing at the Office of Administrative Law (OAL). Woodland may request a hearing to challenge either the

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Curtailment of Readmissions  
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factual survey findings or the curtailment, or both. Woodland must advise this Department within 30 days of the date of this letter if it requests an OAL hearing regarding the curtailment.

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 Woodland is owned by a corporation, representation by counsel is required. In the event of an OAL hearing regarding the curtailment, Woodland 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.

Due to the emergent situation and the immediate and serious risk of harm posed to the residents, the Department will not hold the curtailment in abeyance during any appeal of the curtailment.

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. 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

May 20, 2022  
E-mail ([Mspiegel@woodlandbehavioral.com](mailto:Mspiegel@woodlandbehavioral.com))  
Certified and Regular Mail  
Control # X21036

C. Woodland Service List