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 Bristal at Woodcliff Lake	:	NOTICE OF ASSESSMENT OF PENALTIES
(NJ Facility ID# NJ 02A016)	:	

TO: Mary Ellen McKeon, Administrator (mmckeon@ultimatecaremgmt.com)
The Bristal at Woodcliff Lake
364 Chestnut Ridge Road
Woodcliff Lake, NJ 07677

Dear Ms. McKeon:

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 Bristal at Woodcliff Lake (the facility) on August 18, 2022, for the purpose of a conducting a complaint survey. The report of this visit, which is incorporated herein by reference, substantiated a violation of N.J.A.C. 8:36-3.4(a), which requires the

facility administrator or designee to ensure the development, implementation and enforcement of all policies and procedures. The complaint survey also established a violation of N.J.A.C. 8:36-7.2(d)16, which requires that a resident be assessed by a registered nurse for special treatments and procedures.

Based on observation, interview, and record review, survey determined that the facility failed to assess a resident for the use of a mechanical Hoyer lift in accordance with the manufacturer's specifications, and that the facility failed to develop and implement policies and procedures to ensure that a mechanical Hoyer lift used in the facility was in good working order in accordance with manufacturer's instructions.

Resident # 1 was readmitted to the facility from a rehabilitation facility on May 2, 2019, with a privately owned mechanical lift for transfers from one surface to another. A review of the resident's care plan revealed that the facility developed a care plan related to the transferring of the resident which required the resident to transfer safely with the assistance of two staff using a Hoyer lift. There was no record in the assessment that the facility conducted an assessment for the use of the mechanical lift to identify appropriate measures to ensure the safety and operability of the lift for the resident. The resident's progress notes revealed two staff were present during the transfer on May 12, 2022, a Private Duty Aide (PDA) from the home health agency and a certified nurse aide (CNA) from the facility. During the transfer, the resident fell from the Hoyer lift and sustained a subarachnoid hemorrhage and subdural hematoma. According to the survey report, the caregivers had been properly trained on the use of the Hoyer lift. The resident was transferred to the Emergency Department (ED) and the resident expired that evening. The surveyor reviewed the ED records for the resident dated May 12, 2022, which revealed that the resident expired at 9:46 p.m. on May 12, 2022, with the cause of death determined to be traumatic intraparenchymal hemorrhage.

Survey interviewed the CNA and the PDA who were assisting the resident with the transfer at the time of the fall. Both interviews corroborated the essential facts. The resident fell out of the lift as the resident was being transferred from the wheelchair to the bed; after the wheelchair was removed from under her, the resident's head struck the floor.

Survey interviewed the facility's director of nursing (DON). The DON stated that the facility believed the rehabilitation facility assessed the resident for mechanical lift usage before readmission to the facility and that the mechanical lift transfer portion of the resident's care was to be primarily conducted by the resident's PDA with facility staff providing secondary support. The DON verified the facility did not conduct a mechanical lift assessment to ensure the resident had the right sling size and that the facility did not have measures in place to check the safety and operability of the resident's mechanical lift. During an interview with the surveyor, the facility Administrator concurred with the DON's assessment and offered that the facility had no policy regarding the safe usage and/or operability of equipment that a resident may bring into the facility on their own.

Survey interviewed the DON from the home health agency (HHA). The HHA DON stated that the agency provided a PDA to assist the resident and that a registered nurse was sent to assess the resident. According to the HHA DON, the home health agency's assessment of the resident did not include mechanical lift usage or determining the correct sling size for the mechanical lift. The HHA DON believed that the facility had already completed that portion of the resident's assessment.

Survey reviewed the facility's "Training/In-Service Documentation" policy for safe mechanical lift transfers dated March 4, 2022, which stated that "[t]his guide provides general safety recommendations and is not

a replacement for the manufacturer's instructions. Refer to the manufacturer's instructions for specific use guidelines." Further review of the training revealed "[k]now Your Lift! Patient [resident] falls from lifts may cause injuries, including head trauma, fractures, and death." Further, the document stated, "[c]hoose size of sling based on manufacturer recommendation for patient's [resident] measurements. Choosing correct sling size is critical for safe patient transfer." In addition, "[u]sing the wrong sling or attaching the sling incorrectly may cause serious injury to the caregiver or patient. Position center of sling under patient's [resident's] spine. Ensure patient's head and/or back is supported, if needed."

A HHA nursing visit/contact form," dated April 28, 2022, revealed that the resident had an issue with the Hoyer lift during two transfers conducted by a home health aide in which the lift lowered fast instead of slowly. According to the notes on the form, the resident had called the equipment company and the home health Registered Nurse (RN) questioned the resident about whether the equipment company intended to send out a representative to check the Hoyer lift or replace it, and the resident said the company was not sending a representative out.

During a telephone interview with the equipment company's customer service representative, the representative stated that on March 11, 2022, the resident called the equipment company for a service request because the Hoyer lift's header bar was hard to open or close. However, that request was denied because the lift was no longer covered. Further, the representative stated that the company contacted the resident's insurance provider for a lift replacement, but that request was denied by the insurer on March 23, 2022. The representative added that they received a prescription from the facility on March 31, 2022, requesting a new Hoyer lift, but that the resident did not acquire a new Hoyer lift from the equipment company.

During a surveyor interview with the Administrator and the Director of Nursing (DON), the Administrator stated that the facility was not aware of any concerns with the resident's lift. The DON stated that the facility's physician did not write a prescription for a new Hoyer lift for the resident.

During a surveyor interview with the DON from the HHA, the DON acknowledged being aware of the concern with the resident's Hoyer lift, which was communicated to her on or about April 28, 2022. The HHA DON stated that she believed the resident had acquired a new Hoyer lift prior to the time of the fall, but she acknowledged there was no documentation to verify this.

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 violation of the licensure regulation resulted in actual harm to a resident, a $2,500 penalty is being assessed for each month the facility was not in compliance from the date the resident was readmitted to the facility on May 2, 2019, through the day of death on May 12, 2022. The Department has determined to reduce the penalty from $2,500 per day, to $2,500 per month, for a period of 24 months, in accordance with its discretion pursuant to N.J.A.C. 8:43E-3.4(b) based upon the facility's compliance history and the deterrent effect of the penalty. Therefore, the total penalty for this period is $60,000.

Please be advised that the facility may be subject to additional enforcement actions pursuant to N.J.A.C. 8:43E.

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 X21044.**

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 Bristal at Woodcliff Lake is entitled to challenge the assessment of penalties pursuant to N.J.S.A. 26:2H-14, by requesting a formal hearing at the Office of Administrative Law (OAL). The Bristal at Woodcliff Lake may request a hearing to challenge any or all of the following: the factual survey findings

and/or the assessed penalties. The Bristal at Woodcliff Lake 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 Bristal at Woodcliff Lake is owned by a corporation, representation by counsel is required. In the event of an OAL hearing, the Bristal at Woodcliff Lake 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 Bristal at Woodcliff Lake to comply with N.J.A.C. 8:36-3.4(a) and 7.2(d)16. 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,

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

DATE: October 24, 2022
FACSIMILE
E-MAIL (mmckeon@ultimatecaremgmt.com)
REGULAR AND CERTIFIED MAIL
RETURN RECEIPT REQUESTED
Control # X21044