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

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

KAITLAN BASTON, MD, MSc, DFASAM
Commissioner

In Re Licensure Violation: Artis Senior Living of Eatontown (NJ Facility ID# NJAL13001)	NOTICE OF ASSESSMENT OF PENALTIES

TO: Eileen Mullins, Administrator
Artis Senior Living of Eatontown
147 Grant Avenue
Eatontown, New Jersey 07724

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 Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs set forth at N.J.A.C. 8:36-1.1 et seq.

LICENSURE VIOLATIONS & MONETARY PENALTIES

Staff from the Department's Health Facility, Survey and Field Operations visited Artis Senior Living of Eatontown (hereinafter "Artis Senior Living") on June 20, 2023, and June 21, 2023, for the purpose of conducting a complaint survey. The report of this visit, which is incorporated herein by reference, revealed that the facility failed to provide the surveyor with an incident report, incident report summary, or incident investigation report, in violation of N.J.A.C. 8:36-2.4(d).

Survey staff reviewed records of an incident involving a resident who had an unwitnessed fall in his/her bedroom on April 22, 2023. The facility transferred the resident to the hospital for further evaluation due to complaints of "slight lumbar pain and heavy occiput pain" and sustaining a right occipital laceration (occiput/occipital refers to the back of the head or skull). The resident was admitted to the hospital with 16 stitches for the laceration sustained on the back of the head and was monitored in the neuro intensive care unit. Hospital records revealed the resident had multiple seizure-like events and a CT scan was done which revealed a new small area hemorrhage. The resident later expired on May 7, 2023. As part of the investigation, survey staff requested that the facility provide its investigation about the fall. The Executive Director (ED) told the surveyor that the investigation was written on the incident report and that the facility was not obligated to provide the surveyor with the incident report.

Pursuant to N.J.S.A. 26:2H-5 (e), health care facilities must furnish to the Department of Health reports and information requested to effectuate the provisions and purposes of the act. In addition, pursuant to the Patient Safety Act, N.J.S.A. 26:2H-12.23 et seq., a health care facility must report to the Department every serious preventable adverse event that occurs in that facility. N.J.S.A. 26:2H-12.25(c). "'Serious preventable adverse event' means an adverse event that is a preventable event and results in death or loss of a body part, or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from a health care facility." N.J.S.A. 26:2H-12.25(a). While federal law provides protections against the unauthorized disclosure of protected health information, uses and disclosures for public health activities, including public health investigations, are specifically excluded from the requirement to obtain authorization or to provide an opportunity to agree or object. 45 C.F.R. §164.512(b). Accordingly, the regulations governing assisted living facilities provide that "[s]urvey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and patient records and conferences with patients." N.J.A.C. 8:36-2.4(d). And see N.J.A.C. 8:43 E-5.2(c) (applicable to all heath care facilities).

The facility is in violation of N.J.A.C. 8:36-2.4(d) for failing to provide the surveyor with the incident report, the incident report summary, and the incident investigation report. The facility's argument that an incident report is an "internal document" that does not have to be produced in response to a surveyor inquiry is inapposite. Both reportable events and non-reportable events are afforded confidentiality protections and restrictions on disclosure and use, but the Department, nevertheless, retains authority to exercise its investigative, disciplinary, and enforcement powers within defined parameters.

In accordance with N.J.A.C. 8:43E-3.4(a)(11), and because the violations of N.J.A.C. 8:36-2.4(d) are violations of regulations related to a failure to report information to the Department as required by statute or licensing regulation, after reasonable notice and an opportunity to cure the violation, $250.00 per day is assessed from June 20, 2023, the date the surveyor requested the incident report and the ED stated they do not have to provide the incident report to December 5, 2023, the day an acceptable POC was received and the facility agreed in the POC to provide the Department with the requested documents department in the future. Thus, the total penalty assessed for this violation is $41,250.

The facility is in also violation of N.J.A.C. 8:43E-2.4(d) Plan of Correction ("POC"). The facility repeatedly failed to submit an acceptable Plan of Correction for each of the deficiencies set forth in the June 21, 2023, survey statement of deficiencies. The facility was notified on September 8, 2023, that the POC that was due on August 31, 2023, and submitted on August 29, 2023, was unacceptable because: 1) the POC did not follow the format discussed and set forth in the Required Elements of a Plan of Correction document which was provided to the Executive Director during the exit interview; 2) the first element of each deficiency did not reference the resident or state what corrective action the facility took to correct the deficiency; and 3) , the facility did not provide completion dates for correcting each deficiency. On September 19, 2023, the facility submitted a revised POC,, and the Department notified the facility that the POC was unacceptable on September 28, 2023, because the basic format was still incorrect, completion dates for each deficiency were still missing, and the first element of each deficiency did not reference the resident or state what corrective action the facility took to correct the deficient practice. On November 10, 2023, the facility submitted a revised POC . Once again, the POC was still unacceptable because the facility failed to provide completion dates for correcting all deficiencies. On December 5, 2023, an acceptable POC was received, and was approved on December 11, 2023.

In accordance with N.J.A.C. 8:43E-3.4(a)(9), and because the violations of N.J.A.C. 8:43E-2.4(d) are violations of regulations related to a failure to implement an approved plan of correction to the Department as required by statute or licensing regulation, a penalty of $500 per violation may be assessed for each day noncompliance is found. However, because the violations are not deemed to be immediate and serious threats, the Department in its discretion may decrease the penalty assessed based on the number, frequency and/or severity of violations by the facility in accordance with N.J.A.C. 8:43E-3.4(b). Therefore, a penalty of $250.00 per day for 97 days is assessed from August 31, 2023, the date an acceptable POC was due and supposed to be implemented to December 5, 2023, the date the acceptable POC was received and implemented, and the penalty assessed for this violation is $24,250.

Artis Senior Living is hereby assessed penalties amounting to $65,500.

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 X23033.**

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:

Artis Senior 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 facility may request a hearing to challenge any or all of the following: the factual survey findings and/or the assessed penalties. Artis Senior Living 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 Artis Senior Living is owned by a corporation, representation by counsel is required.

In the event of an OAL hearing regarding the curtailment, Artis Senior Living 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.

Finally, be advised that Department staff will monitor compliance with this notice to determine whether corrective measures are implemented by Artis Senior Living in a timely fashion. 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.

Thank you for your attention to this important matter and for your anticipated cooperation. Should you have any questions concerning this notice, please contact Lisa King, Office of Program Compliance at Lisa.King@doh.nj.gov.

Sincerely,

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

GR:LK:jc:nj
DATE: May 2, 2024
E-MAIL: EMullins@artismgmt.com
REGULAR AND CERTIFIED MAIL, RETURN RECEIPT REQUESTED
Control# X23033