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: Robert Wood Johnson University Hospital (NJ Facility ID# NJ11202)	:	NOTICE OF ASSESSMENT OF PENALTIES

TO: William Arnold, Administrator
Robert Wood Johnson University Hospital
One Robert Wood Johnson Place
New Brunswick, New Jersey 08901
bill.arnold@rwjbh.org

Dear Administrator Arnold:

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 Manual of Hospital Licensing Standards set forth at N.J.A.C. 8:43G-1.1 et seq.

LICENSURE VIOLATIONS

Staff of the Department visited Robert Wood Johnson University Hospital (Robert Wood Johnson University Hospital) on May 21, 2024, to conduct a complaint survey. The report of this visit, which is incorporated herein by reference, revealed policy violations of N.J.A.C. 8:43G-4.1(a)(18), Patient Rights: freedom from physical abuse.

Facts substantiating this violation follow.

On May 1, 2024, a patient arrived from home to the facility's Emergency Department with complaints of right arm pain.

On May 2, 2024, a case management progress note documented that the patient was recently at an acute rehabilitation facility, unaffiliated with Robert Wood Johnson, where a social worker advised the patient's daughter that the social worker anticipates a discharge to subacute rehabilitation level of care. The patient's

daughter stated that she will have to discuss the matter further with her brother, as the patient will not be agreeable. The social worker noted that, due to the frequency of this patient's falls, rehabilitation is encouraged.

Physical Therapy Evaluation notes further documented on May 3, 2024, that the patient "will benefit from rehab to address noted impairments and optimize patient's functional status for safe return home with family. ... ."

On May 5, 2024, an addendum written by a physician stated that the patient's child at the patient's bedside "does not know the patient's history well and appeared to be making up information." The physician noted concerns, stating, "I am highly concerned about this patient being a victim of elder abuse/neglect given multiple falls and extensive fractures apparent on imaging. Home is not a safe environment." The physician indicated that the matter would be referred to a social worker for a safety assessment. According to the physician, "[p]atient needs to find a new living situation under monitored conditions. ..."

Also, on May 5, 2024, a progress note documented by a licensed social worker, stated that the social worker received a "chat yesterday from internal medicine, suspecting abuse of neglect due to multiple falls and extensive fractures." The social worker added case management leadership to the chat to best determine how to proceed and help discharge the patient safely.

On May 6, 2024, a disagreement among team members about whether elder abuse was occurring led to a progress note in the patient's medical record, which recommended a referral to Adult Protective Services (APS) for further investigation concerning the patient's discharge.

A discharge order was placed in the medical record on May 11, 2024, by the Resident of Internal Medicine. The discharge summary stated that, while the patient was recommended for rehabilitation, the patient and family prefer that the patient be discharged to the patient's home. The order further states that, given the patient's frequent and extensive fractures, an Adult Protective Services evaluation is also planned. A social worker was reminded of this need on the day of discharge.

On May 14, 2024, a progress note was documented by another social worker stating that Adult Protective Services was called, and that a "Representative did question why we [discharged the patient] home if we thought there was abuse/neglect."

On May 21, 2024, that same social worker, who was involved with the discharge of the patient, expressed a discomfort with the patient being discharged into the community with family, because there was suspected abuse or neglect. The family of the patient declined having the patient discharged to a skilled nursing facility due to cultural beliefs and values. The social worker made referrals for community resources and services, and last spoke with the patient's family on May 10, 2024, to discuss a discharge plan, but the patient was subsequently discharged on May 11, 2024, without the social worker's knowledge. The social worker stated that the patient should have never been discharged from the facility on a weekend without speaking to someone from Adult Protective Services due to the suspicion of abuse and/or neglect in the home of the patient.

On May 21, 2024, an interview was conducted with a physician. The physician learned of the patient's history and saw images of multiple fractures. The physician identified "multiple red flags." According to the physician, the "first red flag was because [the patient] has so many injuries that could have been prevented. The second red flag was when I spoke with the [patient's child] it seemed like [the child] was so disconnected and almost laughing at the fact of trauma presented." The physician advised the oncoming medical team and social work of concerns for abuse. The physician also stated, "If I thought a patient was being abused, I would keep the patient in the hospital until the patient is safe."

On May 21, 2024, an interview was also conducted with a social worker, who stated "APS asked why the patient went home." The social worker responded by saying, "I knew this conversation would happen and that APS would be disappointed that she was discharged. I didn't think she was going to be discharged over the weekend."

And on May 21, 2024, a case manager stated that the patient should not have been discharged on May 11, 2024, because of possible abuse and/or neglect in the home, due to the patient's history of multiple falls in less than six months, resulting in multiple fractures.

On May 22, 2024, an interview was conducted with the Director of Case Management and Social Work. The Director stated that if he or she felt that a patient who was being discharged home to the patient's family where abuse and/or neglect was suspected, then the Director would apply for guardianship of the patient. The Director also expressed a feeling that the patient was not discharged in a safe manner. And the Director stated that "someone" should have interviewed the patient apart from family members to get the exact feelings of the patient being discharged to the home with family.

Finally, on May 22, 2024, a case manager confirmed a failure to document the discharge of the patient in the patient's medical record. The case manager stated that in hindsight the patient should not have been discharged on May 11, due to suspected abuse and/or neglect.

Conclusions of law follow.

In sum, during its inspection, surveyors concluded that the facility violated N.J.A.C. 8:43G-4.1(a)(18), Patient Rights. Specifically, surveyors determined that the facility failed to implement the facility policy, "Elder Abuse RWJUH New Brunswick." This policy states that "[i]f there is substantial evidence or reason to suspect that the patient is being abused and/or neglected, the social worker will refer the patient to Adult Protective Services Unit with the county of the patient's residence. ..." The policy further states that "[t]he social worker will collaborate with the Adult Protective Services Unit and will refer to the other community agencies/resources, as appropriate, to establish ongoing support, care and follow-up. ...".

MONETARY PENALTIES

N.J.A.C. 8:43G-4.1(a)(18), Patient Rights
N.J.A.C. 8:43E-3.4(a)(8) provides that the Department may assess a monetary penalty of $1,000 per violation "where ... 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 or patient's rights is found...." The $1,000 penalty may be assessed for each day the facility fails to comply with the administrative rule. The Department is assessing a $1,000-per-day penalty for the facility's deficiencies for the period May 5, 2024, to May 23, 2024. These dates correspond to the time the facility first violated its Elder Abuse RWJUH New Brunswick policy, when it first acknowledged a legitimate concern about possible elder abuse, to its eventual Plan of Corrective Action, where the deficiency was corrected and implemented on May 23, 2024. Thus, the total penalty assessed for these violations is ($1,000 x 18 days = $18,000).

The total amount of this penalty (**$18,000**) must 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 # AX24048.**

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

Robert Wood Johnson University Hospital 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 the factual survey findings and/or the assessed penalties. Robert Wood Johnson University Hospital 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 Robert Wood Johnson University Hospital is owned by a corporation, representation by counsel is required. In the event of an OAL hearing regarding the curtailment, Robert Wood Johnson University Hospital 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 Robert Wood Johnson University Hospital 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 Nadine Jackman, Office of Program Compliance at Nadine.Jackman@doh.nj.gov.

Sincerely,

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

LK:ss;GR
DATE: April 25, 2025
E-MAIL: bill.arnold@rwjbh.org
REGULAR AND CERTIFIED MAIL, RETURN RECEIPT REQUESTED
Control# **AX24048**