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:	:	DIRECTED PLAN OF CORRECTION
Summit Oaks Hospital (NJ Facility ID# 52006)	:	

TO: Perry Iasiello-COO
Summit Oaks Hospital
19 Prospect Street
Summit, NJ 07901

As you were notified by verbal order on May 23, 2024, effective immediately, the Department of Health ("Department") is imposing a Directed Plan of Correction (DPOC) requiring Summit Oaks Hospital ("Summit Oaks") to retain the services of a Professional Security Consultant and Consultant Administrator.

These enforcement actions are being taken in accordance with the provisions set forth at N.J.A.C. 8:43E-2.4 (Plan of Correction) and 3.1 (Enforcement Remedies Available), after Staff from the Department's Health Facility Survey and Field Operations (HFS&FO or Survey) were on-site at Summit Oaks Hospital and found significant deficiencies in the facility's measures to address safety and security.

LICENSURE VIOLATIONS:

The Department has received credible evidence of deficient safety and security staffing practices at Summit Oaks Hospital, a psychiatric hospital. Survey staff were on site at Summit Oaks Hospital on May 31, 2023 and based on their observations, interviews and review of pertinent Facility documentation, it was determined that the Facility violated the following: N.J.A.C. 8:43E-11.4(a) (Violence Prevention in HCF: Violence Prevention Committee Plans and Procedures); N.J.A.C. 8:43E-11.4(d)(1)(2)(3)(Violence Prevention in HCF: Violence Prevention Committee Plans and Procedures); N.J.A.C. 8:43E-11.7(2) (Violence Prevention: Completion Violence Risk Assessment); N.J.A.C. 8:43E-11.8(a)(b)(4) (Implementation of Methods to Reduce Identified Risk); N.J.A.C. 8:43E-11.11(F) (Violence: Incident Response Investigation and Reporting); N.J.A.C. 8:43G-26.2(a)(2) (Psychiatry: Policies and Procedures); N.J.A.C. 8:43G-26.12(b)

(Psychiatry: Staff Education); N.J.A.C. 8:43G-26.14(a) (Psychiatry: Quality Assurance Methods). The Department may cite additional deficiencies based upon completion of the final survey report.

The Survey team substantiated the following deficient practices: the failure to establish a violence prevention committee; the failure to ensure that at least 50 percent of the violence prevention committee members are health care workers who engage in direct patient contact; the failure to ensure that at least two members of the violence prevention committee, with at least one member being a direct care staff member, conduct walk through surveys of all worksite areas at least annually; the failure to ensure the training and posting of security personnel is used as a measure to counteract risk factors identified on the violence risk assessment; the failure to ensure the violence prevention committee reviews incident reports and makes recommendations for follow-up, changes to procedures, or additional staff training; the failure to ensure that 1) smoking materials such as cigarette lighters, are utilized in accordance with facility property, 2) environmental safety issues are identified and mitigated, 3) ligature risks identified on Environmental Risk Assessments are mitigated; 4) staff assigned as "Code 85" responders are available to respond to psychiatric emergencies; the failure to ensure that the staff receive Handle With Care training annually, in accordance with Facility policy; and the failure to ensure that an investigation and subsequent action plan is conducted for incidents regarding patient safety and security concerns.

A survey report detailing all the deficiencies and factual findings was sent to the facility on December 18, 2023. The survey report is incorporated herein by reference. To date, the facility has not submitted an acceptable Plan of Correction to address all of the deficiencies.

DIRECTED PLAN OF CORRECTION:

a. The facility must retain the full-time, on-site services of an Administrator Consultant in accordance with N.J.A.C. 8:34-1.1 et seq., who shall be responsible for consultation services concerning the day-to-day operations of the facility. The Administrator Consultant must be approved by the Department. The facility shall provide the name and resume of the proposed Administrator Consultant by submitting the name and resume to Christina.Farkas@doh.nj.gov, and Kara.Morris@doh.nj.gov, Gene.Rosenblum@doh.nj.gov and Lisa.King@doh.nj.gov by 12:00 noon on May 31, 2024. The Administrator Consultant shall be present in the facility for no less than 40 hours per week, with documented coverage of all shifts and weekends, until further notice from the Department. The approved Administrator Consultant shall be retained no later than the close of business, June 7, 2024. The contract with the consultant shall include provisions for immediate corrective action with applicable state licensing standards. The consultant shall have no previous or current ties to the facility's principals, management and/or employers or other related individuals of any kind, including, but not limited to employment, business, or personal ties. The Administrator Consultant and facility shall submit weekly progress reports, beginning on June 14, 2024, and continuing each Friday thereafter. The progress reports shall be submitted to Christina.Farkas@doh.nj.gov, and Kara.Morris@doh.nj.gov.

The Administrator Consultant shall:

1. Assess the facility's compliance with all applicable state licensing standards and identify areas of non-compliance;
2. Oversee the development, implementation and evaluation of corrective action plans;
3. Develop and implement compliance management systems at the facility;
4. Collaborate with facility leadership to ensure that operating procedures, systems and standards align with compliance requirements;
5. Ensure staff training needed to comply with applicable licensing standards; and,
6. Take other actions as may be necessary to ensure identification of compliance issues and implementation of timely corrective measures.

The weekly progress reports by the Administrator Consultant and the facility should be sent every Friday by 1:00 p.m. to Christina.Farkas@doh.nj.gov, and Kara.Morris@doh.nj.gov. These weekly reports shall include timely status updates regarding:

1. Identified areas of non-compliance;
2. Corrective measures to address identified areas of non-compliance; and,
3. Status of corrective measures implementation.

b. Summit Oaks Hospital must retain the services of a full-time Professional Security Consultant ("PSC"), to begin providing services to the facility no later than June 7, 2024. The PSC shall be experienced and qualified to analyze security measures needed in residential behavioral health care facilities. The facility shall provide the Department with the name and resume of the consultant by May 31, 2024. The resume should be sent to Christina.Farkas@doh.nj.gov, Kara.Morris@doh.nj.gov, Gene.Rosenblum@doh.nj.gov, and Lisa.King@doh.nj.gov. The PSC consultant shall have no previous or current ties to the facility's principals, management and/or employers or other related individuals of any kind, including, but not limited to employment, business, or personal ties. The PSC consultant shall be on-site for no less than 40 hours per week, with documented coverage of all shifts and weekends, until further notice from the Department. The contract with this consultant shall include provisions for immediate corrective action ensuring resident safety is not jeopardized and applicable state licensing standards are met. The PSC shall submit weekly progress reports, beginning on June 14, 2024, and continue each Friday thereafter. The progress reports shall be submitted to Christina.Farkas@doh.nj.gov and Kara.Morris@doh.nj.gov.

The DPOC 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 to determine whether corrective measures are implemented by the Facility in a timely fashion. Failure to comply with these and other applicable requirements, as set forth in the pertinent rules and regulations, may result in the imposition of additional enforcement actions.

Please also be advised that you may be subject to other enforcement remedies in addition to this order.

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 (609-376-7742).

Sincerely,

Gene Rosenblum

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

DATE: May 24, 2024
FACSIMILE 909-522-7098
E-MAIL: perry.iasiello@uhsinc.com
REGULAR AND
CERTIFIED MAIL:
RETURN RECEIPT REQUESTED
Control # AX24014

c. Stefanie Mozgai
Pamela Lebak
Kimberly Hansen
Michael Kennedy
Gene Rosenblum
Lisa King