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

MIKIE SHERRILL
Governor

DR. DALE G. CALDWELL
Lt. Governor

DR. RAYNARD E. WASHINGTON
Commissioner

In Re Licensure Violation:

Terraces at Parke Place

(NJ Facility ID# NJ35A003)

NOTICE OF ASSESSMENT
OF PENALTIES

TO: Lori Udell, Administrator
Terraces at Parke Place
661 Delsea Drive
Sewell, New Jersey 08080

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 the Department of Health (the "Department") is authorized to inspect all health care facilities and to enforce the Standards for Licensure of Assisted Living 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 Terraces at Parke Place (hereinafter "Terraces") on May 20, 2025, for the purpose of conducting a complaint survey. The report of this visit is incorporated herein.

The facility was in violation of N.J.A.C. 8:36-4.1(a)(22), which requires each assisted living provider to post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care.

Based on interviews, record review, video surveillance, and facility documentation, it was determined that the facility failed to protect Resident #2 from multiple incidents of staff-to-resident physical abuse and failed to take immediate and effective action to ensure a safe environment. This deficient practice resulted in serious injury to the resident and exposed broader systemic issues regarding the facility's response to abuse allegations, staff supervision, internal communication, and adherence to policy.

Resident #2, who had been admitted in December 2024 with a diagnosis of dementia, was involved in multiple confirmed abuse incidents between May 6 and May 8, 2025. On May 9, 2025, the Department received a Facility Reportable Event (FRE) from the facility, stating that two staff members had physically abused Resident #2 on May 8, 2025. A second FRE was submitted on May 12, 2025, following a report from the resident's responsible party (RP), who suspected that a previously reported fall on May 6, 2025,

may have also involved abuse. Upon further review, the facility's Administrator confirmed this concern after viewing surveillance footage that showed a Certified Nursing Assistant (CNA) pushing Resident #2 to the ground.

The surveyor's review of surveillance footage and medical records confirmed the severity of the abuse. On May 6, 2025, at approximately 3:43 a.m., video footage showed a CNA pulling Resident #2 from another resident's room and pushing the resident to the floor. On May 8, 2025, beginning at 12:43 a.m., two Home Health Aides (HHAs) were recorded engaging in multiple acts of physical aggression against the resident: pushing the resident over a recliner, holding the resident down by force, dragging the resident across the floor, and stomping on them. Despite these disturbing actions, the CNA who abused Resident #2 on May 6 continued to be scheduled in the Special Needs Unit (SNU) with access to the resident until May 9, 2025. Further investigation revealed additional failures. Resident #2 was transferred to the hospital on May 6, following the initial abuse incident, under the belief that they had sustained injuries from a fall. No internal suspicion of abuse was documented at that time. It was only after the resident disclosed being hit on May 8—and after further video footage was reviewed—that the facility initiated an investigation. According to the Director of Wellness (DW) and the Administrator, action was not taken to review the May 6 footage until prompted by the RP's concerns. The delay in both recognition and intervention allowed further abuse to occur while the perpetrating staff members remained on shift.

Review of staffing schedules confirmed that the CNA from the May 6 incident continued to work in the SNU with Resident #2 until their removal on May 9. Facility records also indicated discrepancies between staff accounts and surveillance footage, and staff statements were obtained only after external prompting. These findings demonstrate a significant breakdown in the facility's abuse reporting and internal monitoring systems. The surveyor reviewed the facility's policies titled "Abuse and Neglect: Identifying and Reporting" (dated April 20, 2017) and "Resident Rights, Protecting and Ensuring" (dated March 21, 2013). These policies clearly outline the facility's responsibility to maintain a safe and abuse-free environment, require that staff report all suspected abuse, and mandate the removal of staff pending investigation when there is suspicion of harm. The facility failed to uphold these policies. Staff did not initiate appropriate abuse investigations in a timely manner, nor did they prevent further contact between the abuser and the resident. These failures placed Resident #2 in continued danger, delayed necessary protection measures, and demonstrated a lack of effective administrative oversight. Based on these findings, the surveyor determined that the facility violated resident rights under N.J.A.C. 8:36-4.1(a)(22) by failing to ensure that Resident #2 lived in a safe environment, free from abuse.

In accordance with N.J.A.C. 8:43E-3.4(a)(10), a penalty of $2,500 is assessed for the facility's violation of N.J.A.C. 8:36-4.1(a)(22), which resulted in actual harm to Resident #2 and placed the resident at an immediate and serious risk of further harm. The penalty is assessed from May 6, 2025, through May 9, 2025, during which the facility failed to recognize and investigate the abuse, allowed the staff member responsible for the May 6, 2025 incident to continue working in the Special Needs Unit with access to Resident #2, and failed to implement immediate protective measures to ensure the resident's safety. A penalty of $2,500 per day for four (4) days results in a subtotal penalty of $10,000.

Effective May 10, 2025, the Immediate Jeopardy was lifted; however, the facility remained out of compliance with N.J.A.C. 8:36-4.1(a)(22) due to continuing deficiencies in its abuse reporting and investigation processes, staff supervision, internal communication, administrative oversight, and implementation of policies designed to protect residents from abuse. Pursuant to N.J.A.C. 8:43E-3.4(a)(8), which authorizes a penalty of $1,000 per day where an actual violation of a resident's rights is found and noncompliance continues, a penalty of $1,000 per day is assessed from May 10, 2025, through July 8, 2025, the date the facility achieved substantial compliance through implementation of its corrective actions, including completion of staff in-service education on resident rights and abuse prevention policies. A penalty of $1,000 per day for 55 days results in a subtotal penalty of $60,000.

The total penalty imposed for these violations is $70,000.

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 X25159.**

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:

Terraces 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. Terraces 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 Terraces is owned by a corporation, representation by counsel is required.

In the event of an OAL hearing regarding the curtailment, Terraces 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 Terraces 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,

Lisa King /jc

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

GR:LK:jc:nj
DATE: July 10, 2026
REGULAR AND CERTIFIED MAIL, RETURN RECEIPT REQUESTED
Control# X25159